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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

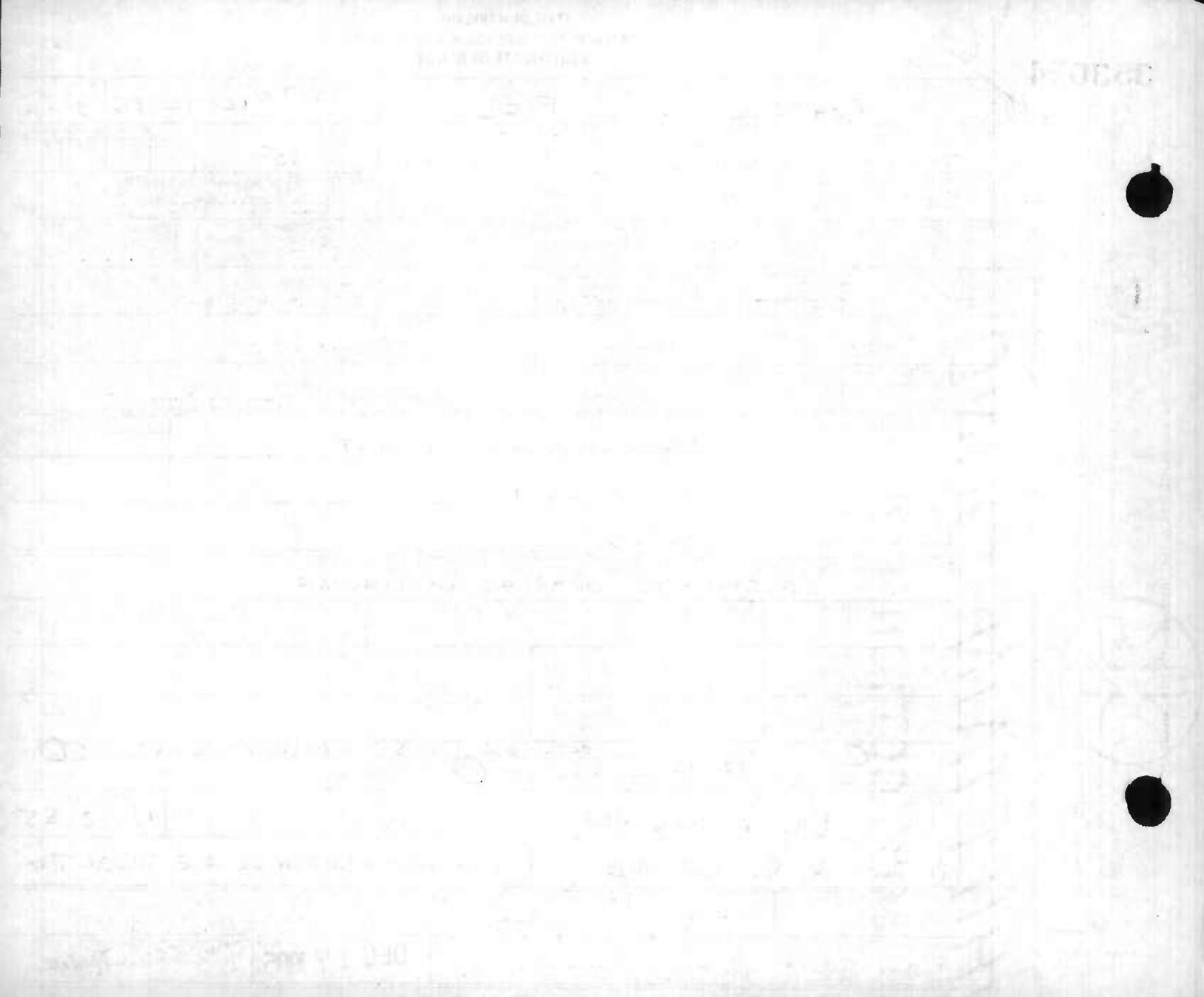
1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		Beatrice <b>BEATRICE</b>	MIDDLE H.	LAST <b>Fiel</b>	2a. DATE OF DEATH December 12, 1985	MONTH 12	DAY 12	YEAR 85	2b. HOUR 305 AM		
3 SEX Female		4 RACE White	5. DATE OF BIRTH July 17, 1900 7 17 00	6. AGES IN YEARS LAST BIRTHDAY 85	IF UNDER 1 YEAR MONTHS 85				IF UNDER 24 HRS HOURS 305 MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County,				MD.			
10. CITY OR TOWN OF DEATH USA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Fairland Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk			12b. KIND OF BUSINESS OR INDUSTRY G.P.O.			
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Burtonsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 4010 Dustin Road				
14. FATHER'S NAME FIRST Lafayette		MIDDLE	LAST Turner	15. MOTHER'S MAIDEN NAME (Unobtainable)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None		16b. SOCIAL SECURITY NO. 229-44-9182		17. INFORMANT Betty Jean Road		ADDRESS Same as item # 13					
18 CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<b>CARDIOPULMONARY ARREST</b>									
DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPOTENSION</b>											
		DUE TO, OR AS A CONSEQUENCE OF (c) <b>SEPSIS</b>									
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		<b>METASTATIC OVARIAN CARCINOMA</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) this hospital attended the deceased from <b>OCTOBER 19, 85</b> , to <b>DECEMBER 12, 1985</b> , that (I) we last saw the deceased alive on <b>12-12-1985</b> , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Charles M. Benner MD</b>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <b>12-12-85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHARLES M. BENNER MD</b>		22e. ADDRESS <b>11161 NEW HAMPSHIRE AVE, SILVER SPRG.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/14/85		23c. NAME OF CEMETERY OR CREMATORIAL Mt Comfort			23d. LOCATION CITY OR TOWN Fairfax Co., Virginia		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME Cunningham Funeral Home, Inc.		ADDRESS Cameron & Alfred Sts Alexandria, Va.			25a. DATE REC'D. BY REGISTRAR DEC 17 1985			25b. REGISTRAR'S SIGNATURE <b>Sandra Henderson Pendell</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, file it in the funeral director's office. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal of the deceased. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other than medical event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 85 5 3 5 0 5 0											
1. DECEASED NAME (TYPE OR PRINT)	FIRST MELVIN D	MIDDLE DAVISON	LAST FIELDS	2. DATE OF DEATH MONTH DAY YEAR	DAY	YEAR	2b HOUR HRS				
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH 4 DAY 30 YEAR 12	6. AGE (IN YEARS AT BIRTHDAY) 73 yrs	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	HOURS	MIN.				
7a. BIRTHPLACE NEW YORK	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.								
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION HOLY CROSS HOSPITAL	12a. USUAL OCCUPATION BIOCHEMIST	12b. KIND OF BUSINESS OR INDUSTRY US GOVERNMENT								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 800 LANARK WAY	----20901					
14. FATHER'S NAME BENJAMIN	MIDDLE FELDMAN	15. MOTHER'S MAIDEN NAME IDA	16. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO OR UNKNOWN <input type="checkbox"/> (WW II FOR DATES)			16b. SOCIAL SECURITY NO. 485-05-6173	17. INFORMANT MARIAN G. FIELDS, ADDRESS 800 LANARK WAY SILVER SPRING, MARYLAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GRAY NEGATIVE SEPTIC SHOCK				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				METASTATIC CARCINOMA							
DUE TO, OR AS A CONSEQUENCE OF (c) OF COLON .											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION X	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED X				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH X DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) X									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET X	CITY OR TOWN	COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>12-28-1985</u> to <u>12-31-1985</u> , that (I) (we) last saw the deceased alive on <u>12-31-1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>AQ Adas</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ASIF S. QADRI</u>				22e. ADDRESS <u>4713 - BERWYN RD, College Pk MD</u>							
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 1/3/1986	23c. NAME OF CEMETERY OR CREMATORIUM WELLWOOD CEMETERY	23d. LOCATION TOWNSHIP PINELAWN, LONG ISLAND, NEW YORK							
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET N. W. WASHINGTON, D. C.				25a. DATE REC'D. BY REGISTRAR JAN 7 1986	25b. REGISTRAR'S SIGNATURE <u>Jeanne Davidson-Randall</u>						

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23/82



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 2, 3, AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1A. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 prior to burial, cremation, or removal.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												35061		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE KNOWN OF ESTI. DEATH MATED			MONTH	DAY	YEAR	2d. HOUR		
Willie			James	Fiveller		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	126	85	1985	09:55 AM		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR		
Male	Black	2 68 30	55			<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	126	85	1985	09:55 AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH					
North Carolina			U.S.A.			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Montgomery MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Gaithersburg			Shady Grove Adventist Hosp			Labor			Const. Co.					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
Wash. D.C.			None			Wash. D.C.						1906 - C ST. NE.		
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST					
Willie				Henshaw	Maggie									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
no			239-34-7401			Mary Blakely 704 Walkup Ave Monroe NC.								
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.			Due to, or as a consequence of											
(b)			Cerebral arteriosclerosis'											
(c)			Due to, or as a consequence of											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
												YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE			John Tumber			M.D. Deputy			MEDICAL EXAMINER			DATE SIGNED		
EXAMINER'S NAME (TYPE OR PRINT)			John Tumber			ADDRESS			Bethesda Md.			12-6-85		
23a. BURIAL, CREMATION, REMOVAL (SPECIES)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY	STATE	
Burial			12-13-85			Hillcrest Cemetery			Monroe			Union	NC.	
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
W.W. Chambers come Washington D.C.						DEC 13 1985								

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6.2.11 101st S.A.C.

6.2.11 101st S.A.C.

6.2.11 101st S.A.C.

6.2.11 101st S.A.C.

24 hours of transport, heavy rain, difficult road, 101st S.A.C., 101st S.A.C.

24 hours of transport, heavy rain, difficult road, 101st S.A.C., 101st S.A.C.

24 hours of transport, heavy rain, difficult road, 101st S.A.C., 101st S.A.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove the carbon paper. Please sign and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

007026

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 35082

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Elizabeth	MIDDLE A.	LAST Finn	20. DATE OF DEATH	MONTH Dec.	DAY 27	YEAR 1985	26 HOUR 6:39 AM	
3. SEX			4 RACE	5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Female			Caucasian	MONTH 5	DAY 7	YEAR 1893	92 YRS.	MONTHS DAYS	MONTHS DAYS	IF UNDER 24 HR.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Connecticut			U.S.A.						Montgomery Co., MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Fernwood House			Teacher			Public Schools		
13. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET ADDRESS / ZIP CODE		
Maryland			Montgomery			Potomac			8517 Warde Terrace 20854		
14. FATHER'S NAME			FIRST William	MIDDLE H.	LAST Elliott	15. MOTHER'S MAIDEN NAME			LAST Sullivan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			027-20-0036			D. Francis Finn (son) Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a))			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral vascular accident</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cerebral atrophy</i>			<i>immediate</i>					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cerebral arteriolosclerosis</i>						<i>yes</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d. INJURY OCCURRED  WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____					
22a. I certify that (I) (his/her) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <i>John G. Ward</i>			22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 12/27/85					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John G. Ward</i>			22f. ADDRESS <i>6116 Rockwood, Bethesda 20817</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____		
Burial			30 Dec 85			St. Mary's Cemetery			Lisbon, Conn.		
24. FUNERAL DIRECTOR NAME <i>Capitol Funeral Service, Falls Church, VA</i>			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <i>JAN 3 1986</i>		
DHHM - 16 60M 7/84 (VRA 15, 4)											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

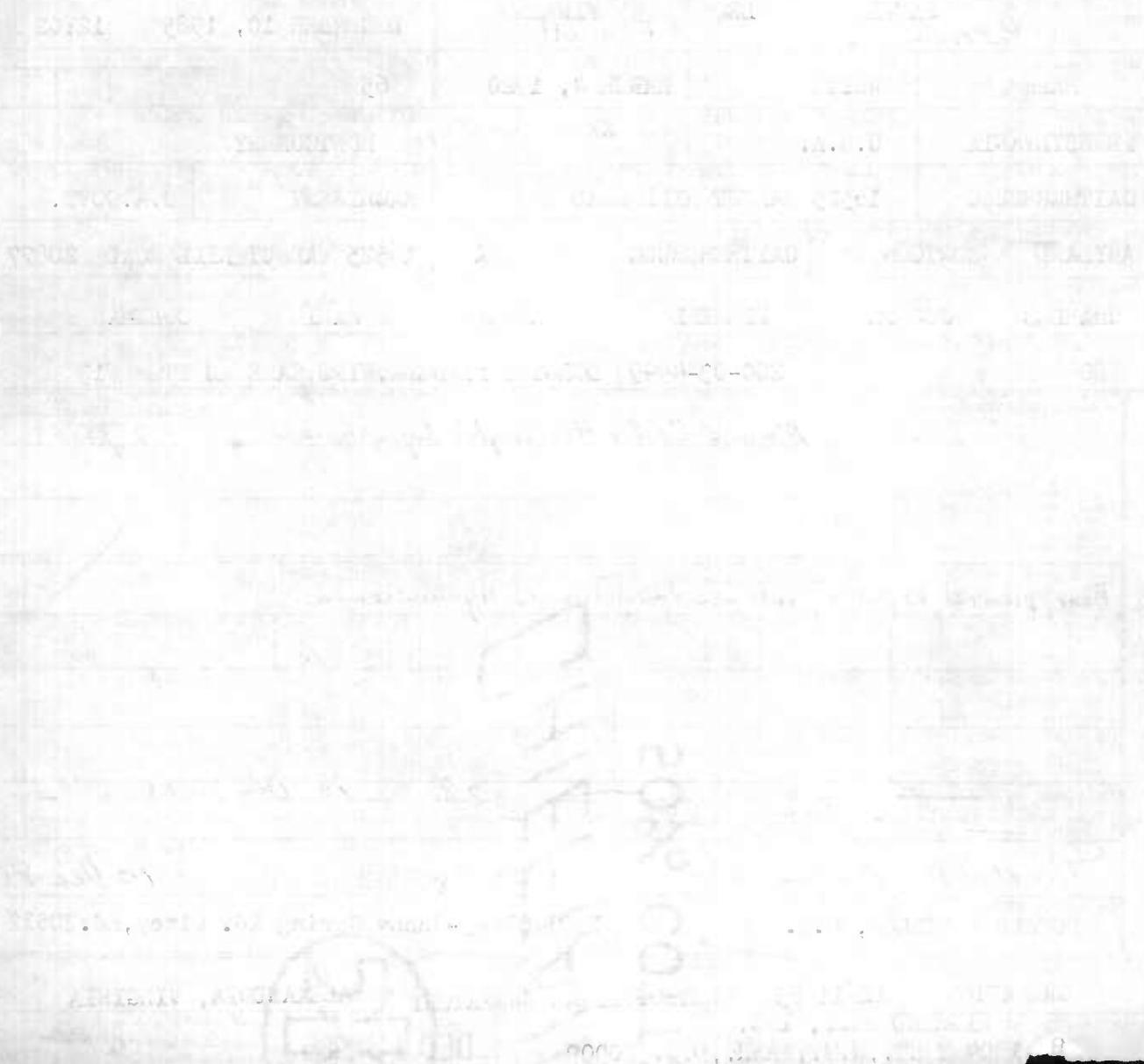
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician (item 1), page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

351149

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 35 35085				
1 - STATE REGISTRAR		1. DECEASED NAME <b>FIRST</b> PATRICK <b>MIDDLE</b> LEO <b>LAST</b> FINNELL Patrick L. Finnell					2a. DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 10, 1985</b>				2b. HOUR <b>12:02 P.M.</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>MARCH 4, 1920</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b>		IF UNDER 1 YEAR <b>MONTHS DAYS</b>		IF UNDER 24 HRS <b>HOURS MIN.</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b>				MD.			
10. CITY OR TOWN OF DEATH <b>GAITHERSBURG</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A HOSPITAL, GIVE STREET ADDRESS) <b>18525 WALNUT HILL ROAD</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MACHINIST</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>U.A.GOV'T.</b>			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>GAITHERSBURG</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>18525 WALNUT HILL ROAD</b>		20877			
14. FATHER'S NAME <b>FIRST</b> CHARLES <b>MIDDLE</b> JOSEPH <b>LAST</b> FINNELL		15. MOTHER'S MAIDEN NAME <b>FIRST</b> KATHRYN <b>MIDDLE</b> MARIE <b>LAST</b> COLEMAN												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>200-03-4999</b>			17. INFORMANT <b>DOROTHY FINNELL, WIFE, SAME AS ITEM #13</b>			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Mixed Cell + Histiocytic Lymphoma</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs.</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)														
{ DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>Bone, pleural, hepatic, splenic involvement. Hypercalcemia.</i>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) <input type="checkbox"/> attended the deceased from _____, 19____, to _____, 19____, that (I) <input type="checkbox"/> was lost saw the deceased alive on <b>6 Dec 1985</b> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did (did not) view the body after death.														
22b. SIGNATURE <i>Donald E. Dillon MD</i>		22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <b>10 Dec 85</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DONALD E DILLON, M.D.</b>		22e. ADDRESS <b>2901 Olney-Sandy Spring Rd. Olney, Md. 20832</b>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>12/11/85</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>METROPOLITAN CREMATORIAL</b>			23d. LOCATION CITY OR TOWN <b>ALEXANDRIA</b> COUNTY STATE <b>VIRGINIA</b>							
24 FUNERAL DIRECTOR NAME: <b>RICHARD RAPP, INC.</b> ADDRESS: <b>1804 T ST., N.W., WASH., D.C. 20009</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 13 1985</b>			25b. REGISTRAR'S SIGNATURE <i>John Anderson - Yandee</i>									

C. 1968



009135

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

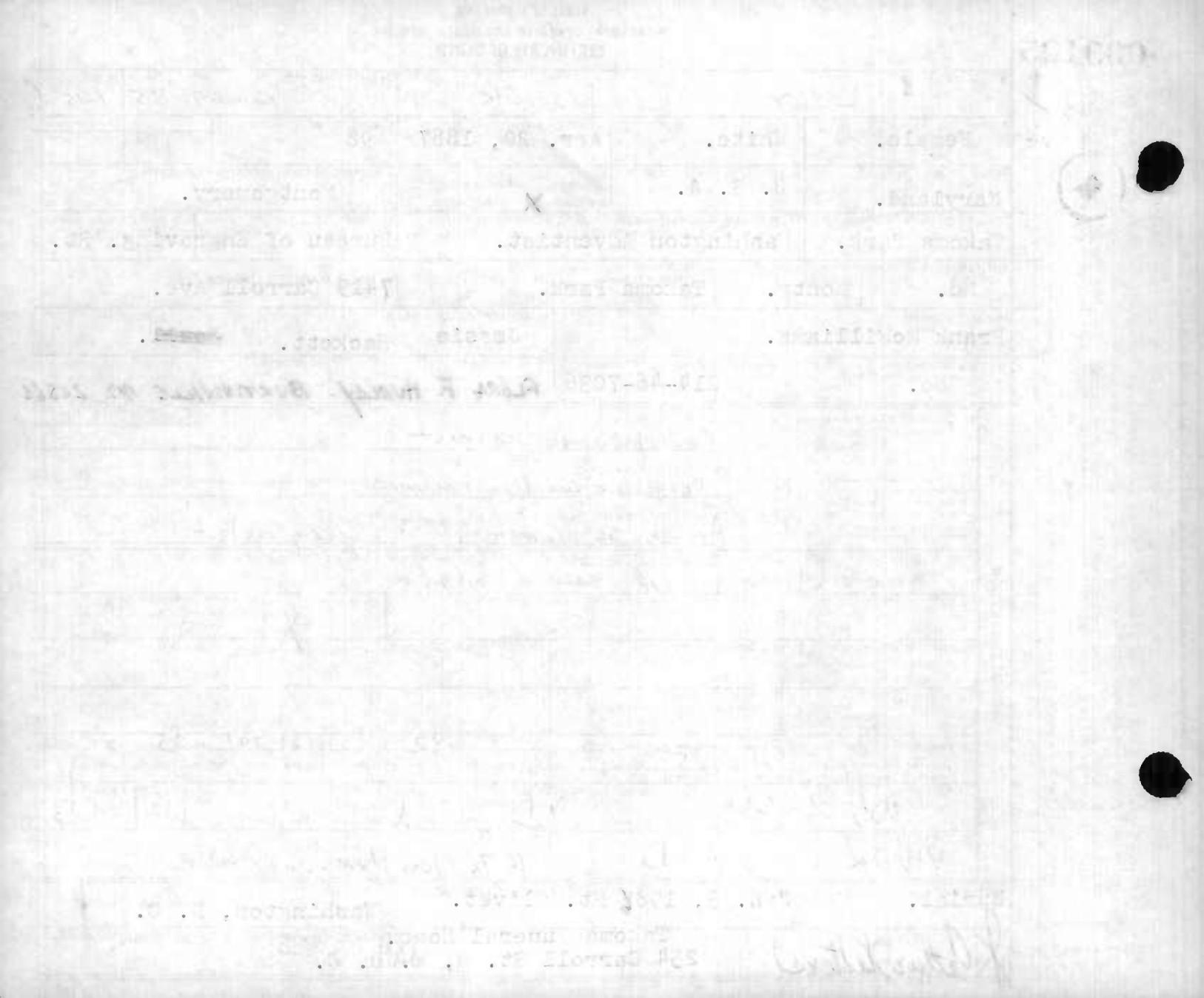
I. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR										
LUCY FISHER							12 - 29 - 85				1:15 P.M.										
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS											
Female.		White.		Apr. 20, 1887		98		MONTHS		DAYS											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY					
Maryland.		U. S. A.				Montgomery.		Takoma Park.				Washington Adventist.		Bureau of Engraving. Rt.		MD.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		19. MEDICAL CERTIFICATION	
Md.		Montg.		Takoma Park		YES <input type="checkbox"/> NO <input type="checkbox"/>		Frank McWilliams.		Jessie Hackett.		No.		214-46-7036		FLORA F. HURLEY. BURNTSVILLE MD. 20866		Cause of Death		Approximate Interval Between Onset and Death	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Cardiac Failure		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (c) Anemia, Septicemia, U.T.I., Gangrene Foot															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?															
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		VIVEK C VAIID		7676 New Hampshire Ave															
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL HOME		23d. LOCATION CITY OR TOWN		23e. REC'D. BY REG. OFFICER		23f. REGISTRAR'S SIGNATURE											
Burial.		Jan. 3, 1985		Mt. Olivet.		Washington, D. C.		J. Arthur Walters		Jan. 3, 1985											
24. FUNERAL DIRECTOR		25. ADDRESS		Takoma Funeral Home		26. REC'D. BY REG. OFFICER		27. REGISTRAR'S SIGNATURE													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If it is not so done, the physician should be detained for one or the burial-arrangement period. Then please remove carbon copies. Page 1 and 2 should be filled in by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use on the burial-arrangement period. Then please remove carbon copies. Page 1 and 2 should be filled in by the attending physician.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner should be notified at once.

BP



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07/84  
25M

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 24. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FILLED OUT AND ATTACHED TO THE BURIAL CEREMONY CARD. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL. BALTIMORE, MARYLAND, 21201

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 35086			
1- STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE KNOWN OF ESTI- DEATH MATED			2b HOUR MONTH DAY YEAR			
MICHAEL DENNIS FLYNN									<input checked="" type="checkbox"/> 12 16 1985 A						
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD		2d. HOUR MONTH DAY YEAR			
Male		Caucasian		08 23 36		49 yrs				12-16-1985 07 M					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. MARRIED NEVER MARRIED DIVORCED		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12e. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13b. KIND OF BUSINESS	
Washington, D.C.		United States		<input checked="" type="checkbox"/>		<input type="checkbox"/>		ROCKVILLE		1203 Gladstone Dr		Manager		Equipment Communication	
10. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		11b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		20851					
MD		Montgomery		Rockville		<input checked="" type="checkbox"/>		1203 Gladstone Dr							
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Fred		Lillian R. Perkins		yes -1963		220 32 6434		Rose Marie Flynn see # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u>												ACUTE			
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last</u> . (b) <u>CARCINOMA OF LUNG</u>												2 yrs			
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?									
						<input type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
			11 P.M. 12 16 19			Found in Bed									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET 1203 Gladstone Dr Rockville Mont			COUNTY STATE Montgomery						
			Home												
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>												
ACTUAL SIGNATURE			TITLE (SPECIFY) M.D. Sept			MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT)			Francis C. Mayle			ADDRESS 8200 Wisconsin Ave Bethesda MD			DATE SIGNED 12/16/85 20851						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Dec. 19, 1985			23c. NAME OF CEMETERY OR CREMATORIALy			23d. LOCATION CITY OR TOWN Alexandria,			COUNTY STATE Virginia			
Cremation						Metropolitan Crematory									
24. FUNERAL DIRECTOR NAME			Robert A. Pumphrey Funeral Homes, ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
P.A. 300 W. Montgomery Av., Rockville, Md.									DEC 19 1985			Elie Davidson - Pender			
DHMH - 17 (VR A15 ME (5))															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be informed by the hospital or attending physician.

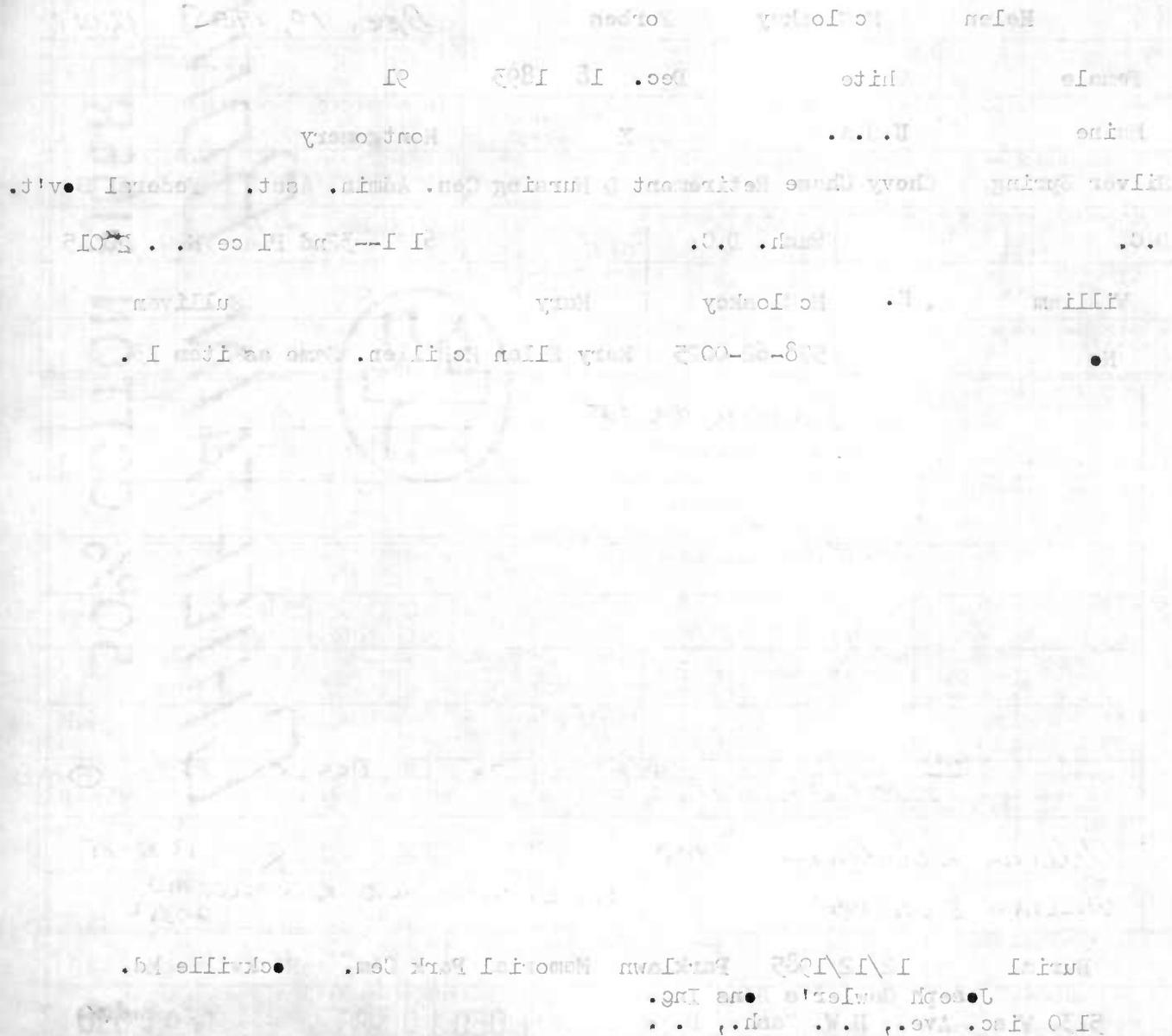
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

352061

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 35087	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>Helen</b>	MIDDLE <b>McCloskey</b>	LAST <b>Forbes</b>	2a. DATE OF DEATH <b>DEC. 10, 1985</b>			MONTH YEAR		
J. SEX			4. RACE <b>White</b>	5. DATE OF BIRTH <b>Dec. 18 1893</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b>			2b. HOUR <b>12:02 P.M.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maine</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE FACILITY, GIVE STREET ADDRESS) <b>Chevy Chase Retirement &amp; Nursing Cen.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Admin. Asst.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Federal Gov't.</b>		
13a. STATE <b>D.C.</b>			13b. COUNTY <b>Wash. D.C.</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>6121-32nd Place N.W. 20015</b>		
14. FATHER'S NAME FIRST <b>William</b>			MIDDLE <b>H.</b>	LAST <b>McCloskey</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b>			MIDDLE	LAST <b>Sullivan</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>578-62-0025</b>			17. INFORMANT <b>Mary Ellen McMillen. Same as item 13.</b>			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>HMO</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (we) attended the deceased from <b>NOV. 25 1985</b> to <b>DEC 10 1985</b> , that (I) (we) last saw the deceased alive on <b>NOV. 25 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.										22c. DATE SIGNED <b>12-10-85</b>	
22b. SIGNATURE <b>William Silverman</b>			22c. DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILLIAM SILVERMAN</b>			22e. ADDRESS <b>6111 EXECUTIVE BLVD, ROCKVILLE, MD 20852</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12/12/1985</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Parklawn Memorial Park Cem.</b>			23d. LOCATION CITY OR TOWN <b>Rockville Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons Inc.</b>			24b. ADDRESS <b>5130 Wisc. Ave., N.W. Wash., D.C.</b>			25a. DATE REC'D. BY REGISTRAR <b>DEC 16 1985</b>			25b. REGISTRAR'S SIGNATURE <b>J. GAWLER</b>		
DHMH - 16 60M 7/84 (VRA 15-4)											

REVERSE



007066

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 3 5 0 8 8

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)				FIRST Mary	MIDDLE R.	LAST Ford	2a. DATE OF DEATH December 26, 1985	MONTH Dec.	DAY 26	YEAR 1985	2b. HOUR 3:00P
3 SEX Female		4 RACE White		5. DATE OF BIRTH Aug. 25, 1905 <sup>AR</sup>		6 AGE (IN YEARS LAST BIRTHDAY) 80		IF UNDER 1 YEAR MONTHS YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE COUNTRY Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		MD.			
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY own home					
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3309 Estelle Terrace		30901	
14. FATHER'S NAME FIRST William		MIDDLE Luther	LAST Hoover	15. MOTHER'S MAIDEN NAME Sarah						White	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE EXACT DATES) N/A		16c. INFORMANT ADDRESS Nancy F. Skidmore-dau-(same as 13e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma Colon rectosigmoid</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b) _____ (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION <i>Nov 18 1985</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma Colon</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>12-26-85</i> , 1985, to <i>12-26-85</i> , 1985, that (I) (we) last saw the deceased alive on <i>12-26-85</i> , 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Sulkin</i>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED Dec. 26, 1985					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Sulkin, M. D.		22e. ADDRESS 1011 Prince Philip Drive Olney, MD 20832									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 30, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Woodbine Cemetery		23d. LOCATION CITY OR TOWN Harrisonburg Rockingham Va.					
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		25a. ADDRESS 11800 N.H. Ave., Silver Spring, Md.		25b. DATE REC'D. BY REGISTRAR JAN 3 1986		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 may be retained by the funeral director or the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

DHMH - 16 60M 7/B4  
(VRA 15, 4)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified.

357071

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 3 5 0 8 9		
												REG. NO.		
1. FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST Cadie	MIDDLE Nadine	LAST Foster	2a. DATE OF DEATH			MONTH DEC. 12 85	DAY 12	YEAR 85	2b. HOUR 12 <sup>15</sup>	
3. SEX	4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR 71	MONTHS YRS.	DAYS HOURS MIN.		
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring			Holy Cross Hosp			Kitchen Worker			Hospital					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO			13e. STREET ADDRESS / ZIP CODE 9008 3rd Ave 20910		
MD			Montgomery			Silver Spring								
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
FIRST Nathaniel			LAST Scott			FIRST Cristobel			MIDDLE			LAST Bodden		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT (daughter)			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO			261-38-3462			Barbara C. Springer			Same as 13			MOS		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LIVER FAILURE - HEMORRHAGE CONVULSIONS														
DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC END STAGE LIVER DISEASE MOS														
DUE TO, OR AS A CONSEQUENCE OF (c) NON-A-AL-B CHRONIC HEPATIS-CIRRHOSIS YRS														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from JAN 19 85 to DEC 12 19 85, that (I) (we) lost saw the deceased alive on 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death.														
22b. SIGNATURE DEGREE														
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>														
22c. DATE SIGNED 12/12/85														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL Garden of Memories Cemetery			23d. LOCATION Tampa, Florida			23e. ADDRESS		
Burial			17 Dec 85											
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Capitol Funeral Service, Falls Church, VA						DEC 19 1985								

Section C: School enrollment

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5 35090

REG. NO.

FOR  
1- STATE  
REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH EACH PAGE 3 RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Frank</i>	MIDDLE <i>A.</i>	LAST <i>Fraley</i>	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	MONTH 12	DAY 8	YEAR 85	19	2b. HOUR 6:38 P.M.		
2. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH 8 YEAR 10 01	6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	7. IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD <i>12 8 85</i>	MONTH 12	DAY 8	YEAR 85	19	2d. HOUR 6:58 P.M.
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i>			MD.		
10. CITY OR TOWN OF DEATH <i>Rockville</i>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Shady Grove Adventist Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Farmer</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>20877</i>				
13a. STATE <i>Md.</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Gaithersburg</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET ADDRESS <i>17670 Town Crest Dr.</i>							
14. FATHER'S NAME FIRST <i>James</i>			MIDDLE <i>Henry</i>	LAST <i>Fraley</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Isabel</i>			MIDDLE <i>Victoria</i>	LAST <i>Sweeney</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>			16b. SOCIAL SECURITY NO. <i>WWI 213-18-9491</i>			17. INFORMANT ADDRESS <i>Hazel L. Fraley Gaithersburg, Md. 20877</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Chronic obstructive Pulmonary Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>John Gartner</i>		TITLE (SPECIFY) <i>M.D.</i>			MEDICAL EXAMINER <i>Douglas Gartner</i>			DATE SIGNED <i>12-8-85</i>					
EXAMINER'S NAME (TYPE OR PRINT) <i>John Gartner</i>		ADDRESS <i>8218 WISCONSIN Ave Bethesda Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12/11/85</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Lewistown Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Lewistown</i>		COUNTY <i>Frederick</i>		STATE <i>Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Gartner Sandison F.H.</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 12 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Julie Sandison Gartner</i>									
15M 2/80 BP													
DHMH-17 (VRA15ME(5))													



365203

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 3509

REG. NO.

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Mildred E. Frazier						12	16	85	5 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
FEMALE		BLACK		Feb. 29, 1891		94		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MD		U.S.A.				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Gaithersburg		Wilson Health Care Center		Housewife							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)						13a. STREET ADDRESS / ZIP CODE					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
MD		MONTG.		Gaithersburg		YES <input type="checkbox"/>		NO <input type="checkbox"/>		9610 Wightman Rd 20879	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
?		Ross				Hattie Lewis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO		220-50-8402		Jean Prother (cousin) same as #13		initial					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						DUE TO, OR AS A CONSEQUENCE OF (b) cerebrovascular insufficiency yrs DUE TO, OR AS A CONSEQUENCE OF (c) multi-infarct Dementia yrs Diabetes mellitus yrs					
DUE TO, OR AS A CONSEQUENCE OF (b) cerebrovascular insufficiency yrs DUE TO, OR AS A CONSEQUENCE OF (c) multi-infarct Dementia yrs Diabetes mellitus yrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
		Gastric				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from so the deceased died on 12/18/85, to 12/16/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22c. DATE SIGNED 12/16/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Robert Willman, MD		156 Deer Park Dr Gaithersburg MD 20877									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		CITY OR TOWN		COUNTY STATE	
Burial		12-21-85		Brooke Grove Cemetery		Gaithersburg		Gaithersburg		Montg. MD	
24. FUNERAL DIRECTOR NAME		246 N. Washington St. Rockville, MD 20850				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
George R. Snowden						DEC 20 1985		<i>John J. Kavanagh</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Item 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner shall be notified at once.



351138

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned to you, it should be retained for use as the burial/transit permit. Then please remove carbon papers. Please return the original to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **IMPORTANT:** If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 35092				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
<i>Jennie C. Frey</i>					<i>Frey</i>			<i>12-2-85</i>			<i>1985</i>	<i>9:05 A</i>		
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
<i>Female</i>			<i>White</i>		<i>11-28-13</i>			<i>72</i>			MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS			
<i>Wash. DC</i>			<i>USA</i>					<i>Montgomery</i>			MONTHS DAYS			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
<i>Takoma Park</i>			<i>Washington Adventist Hospital</i>		<i>Homemaker</i>									
13a. STATE			13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			14. STREET ADDRESS / ZIP CODE						
<i>Maryland</i>			<i>Prince Geo.</i>		<i>Beltsville</i>			<i>11606 34th Place</i>			<i>20705</i>			
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST					
<i>Jan</i>				<i>Baardse</i>	<i>Classina</i>				<i>Oman</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<i>No</i>			<i>579-01-4654</i>		<i>(son)</i>			<i>John G. Frey</i>			<i>PO Box 321 Boyce, Va, 22620</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrest</i>														
DUE TO, OR AS A CONSEQUENCE OF (b) <i>respiratory failure</i>														
DUE TO, OR AS A CONSEQUENCE OF (c) <i>lung abscess</i>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>renal failure, hepatic failure, severe malnutrition</i>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
								<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)									
			<i>P.M. 19</i>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) <i>this hospital</i> attended the deceased from <i>10-24-1985</i> to <i>12-2-1985</i> , that (I) <i>we</i> last saw the deceased alive on <i>12-2-1985</i> , and that in (my) <i>our</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>we</i> did not view the body after death.														
22b. SIGNATURE <i>C.M. BENNER MD</i> DEGREE												22c. DATE SIGNED <i>12-2-85</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
<i>C.M. BENNER, MD.</i>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTRY			
<i>Burial</i>			<i>Dec. 5, 1985</i>		<i>Fort Lincoln</i>			<i>Brentwood</i>			<i>Pri. Geo. Md.</i>			
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE						
<i>Francis J. Collins</i>								<i>DEC 13 1985</i>						
500 University Blvd. W. Silver Spring, Md. 20901														

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned to you, it should be retained for use as the burial/transit permit. Then please remove carbon papers. Please return the original to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **IMPORTANT:** If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

100% Recycled



100% Recycled

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician or completely filled in by the funeral director. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 and 2 should be filed within 72 hours after death. This certificate should be submitted for use as the Burial Transmittal Permit. Then please remove carbon copy of page 3 and 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 3 3 5 0 9 3			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Ida			M.			Fuller			12-13-85			1730P			
3. SEX Female			4. RACE Negro			5. DATE OF BIRTH MONTH DAY YEAR 12 26 24			6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery			MD.			
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Shady Grove Adventist Hosp.			12a. USUAL OCCUPATION Domestic			12b. KIND OF BUSINESS OR INDUSTRY 100%						
13a. STATE MD			13b. COUNTY Montgomery			13c. CITY OR TOWN GERMANIA			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 11408 SCOVILLE PLACE			
14. FATHER'S NAME Henry T. Fuller			15. MOTHER'S MAIDEN NAME MARY E. JACKSON												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN) NO			16b. SOCIAL SECURITY NO. 215-32-2727			17. INFORMANT Maude Doye (Sister) same as #13			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Severe and failing, Sub paraparaly</i>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Megastrophy, Concomitant breast to bone,</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Crush + Burns.</i> DUE TO, OR AS A CONSEQUENCE OF 1981															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>Hypertension.</i>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <i>12-12-85</i> to <i>12-13-85</i> , that (I) (we) last saw the deceased alive on <i>12-13-85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Ruben C. Cosca</i>			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>12-13-85</i>						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) RUBEN C. COSCA, MD.			22f. ADDRESS 17579 REDLAND ROAD DARWOOD, MD 20855												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-20-85			23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Mem. Park			23d. LOCATION CITY OR TOWN Rockville, Montg. Maryland			COUNTY STATE			
24 FUNERAL DIRECTOR NAME George R. Snowden			246 N. Washington St.			75a. DATE REC'D. BY REGISTRAR DEC 20 1985			25b. REGISTRAR'S SIGNATURE <i>George R. Snowden</i>						

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006038

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3 5 3 5 0 9 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and carbon paper removed, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifying physician must initial the box marked "I" below.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
William E. Gallagher				EDWARD	Gallagher, Sr.	12-24-85				12 48 PM		
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
m		w	MONTH	DAY	YEAR	78	YEARS	MONTHS	DAYS	HOURS	MIN.	
11 09 07												
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
XXXXXX WASH., D.C.		USA			MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Takoma Park		WASH. ADVENTIST HOSP			attorney		LEGAL					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
13a. STATE Md		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13e. STREET ADDRESS / ZIP CODE 2018 Lanier 20910						
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
PATRICK		HENRY		GALLAGHER		MARY		ELLEN		DEAN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO		579-09-4517			WIFE		2018 LANIER DRIVE SILVER SPRING, MD. 20910		2 d			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Respiratory Failure										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		{ (b) Adenocarcinoma of lung						2 mo.				
{ (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/24/85 to 12/27/85, that (we) lost sow the deceased alive on above, (we) did not view the body after death.												
22b. SIGNATURE Peter Sherer		DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/25/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter Sherer		22e. ADDRESS 3947 Ferrara Dr. Wheaton Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE	
BURIAL		12/27/85		ST. JOHNS CEMETERY FOREST GLEN			MONT		MD.			
24. FUNERAL DIRECTOR NAME		FRANCIS J. COLLINS, JR.			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
		500 UNTV. BLVD. W., SILVER SPRING, MD. 20901			JAN 02 1986		John Collins					

100% COLOR



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be attached to used as the Burial-Traffic Permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8535095			
										REG. NO.			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		Dec. 9, 1985			8:21am			
HYMAN L. GALLER													
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.		
Male			White		Sept. 25, 1905			80		YRS.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			Montgomery County, MD.		
Washington, D.C.			U.S.A.										
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring			Holy Cross Hospital							Driver (Ret.)		Taxi	
13a. STATE Maryland			13b. COUNTY P.G.		13c. CITY OR TOWN Riverdale			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5309 Riverdale Rd., #627		(20737)	
14 FATHER'S NAME FIRST Benjamin			MIDDLE	LAST Galler		15 MOTHER'S MAIDEN NAME FIRST Clara			MIDDLE	LAST Worth			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. -----		17 INFORMANT			ADDRESS Riverdale, Md. 20737			Cecelia K. Galler; 5309 Riverdale Rd., #627;		
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Nephritis cardiovascular DUE TO, OR AS A CONSEQUENCE OF (c) Adenovirus heart disease												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 1 week years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diphtheria													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (1) (his/his) attended the deceased from 12-8-1985 to 12-9-1985, that (1) (we) last saw the deceased alive on above, (1) (we) did not view the body after death.													
22b. SIGNATURE <i>J. Aaron MD</i>			DEGREE					22c. DATE SIGNED 12-9-85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. Aaron MD (MD)</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22e. ADDRESS 5830 Cornerstone Silver Spring MD 20910					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/11/85		23c. NAME OF CEMETERY XXXXXX			23d. LOCATION CITY OR TOWN Washington, D.C.		COUNTY	STATE		
24 FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike, Rockville, Md. 20852			25a. DATE REC'D. BY REGISTRAR DEC 13 1985					25b. REGISTRAR'S SIGNATURE <i>Julian David Danzansky</i>					



006047

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 5 0 9 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
Anastazia J. Gambone						12-30-85				5 <sup>10</sup> A.M.	
3. SEX			F	W	SUPERIOR MONTGOMERY 1985	MONTH	DAY	YEAR			
4. RACE					XXXXXX			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
CANADA			U.S.A.						Montgomery		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
SILVER SPRING			HOLY CROSS HOSPITAL			SALESMAN			WOODMOOR GIFT SHOP		
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
MARYLAND			MONTGOMERY			SILVER SPRING			906 DRYDEN COURT 20901		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST		
JOSEPH WALCZYSZYN						ANNA			UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
NO			152-01-5070			WILLIAM A. GAMBONE			SAME AS 13 HUSBAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/29/85 to 12/30/85, that (I) (we) last saw the deceased alive on 12/29/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated below. (If we did not view the body after death, check here) <input checked="" type="checkbox"/>											
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					ADDRESS			<i>301 Georgia Ave Silver Spring MD</i>			12/30/85
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		COUNTY	STATE	
BURIAL		1/2/86		GATE OF HEAVEN			SILVER SPRING, MONT			MD.	
24. FUNERAL DIRECTOR NAME		FRANCIS J. COLLINS, JR.			ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
		500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						JAN 02 1986		<i>Pandelle</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and removed by the funeral director, page 3 should be detached for use in the burial/transit permit. Then please remove carbon copy. If you have any questions concerning this form, contact the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



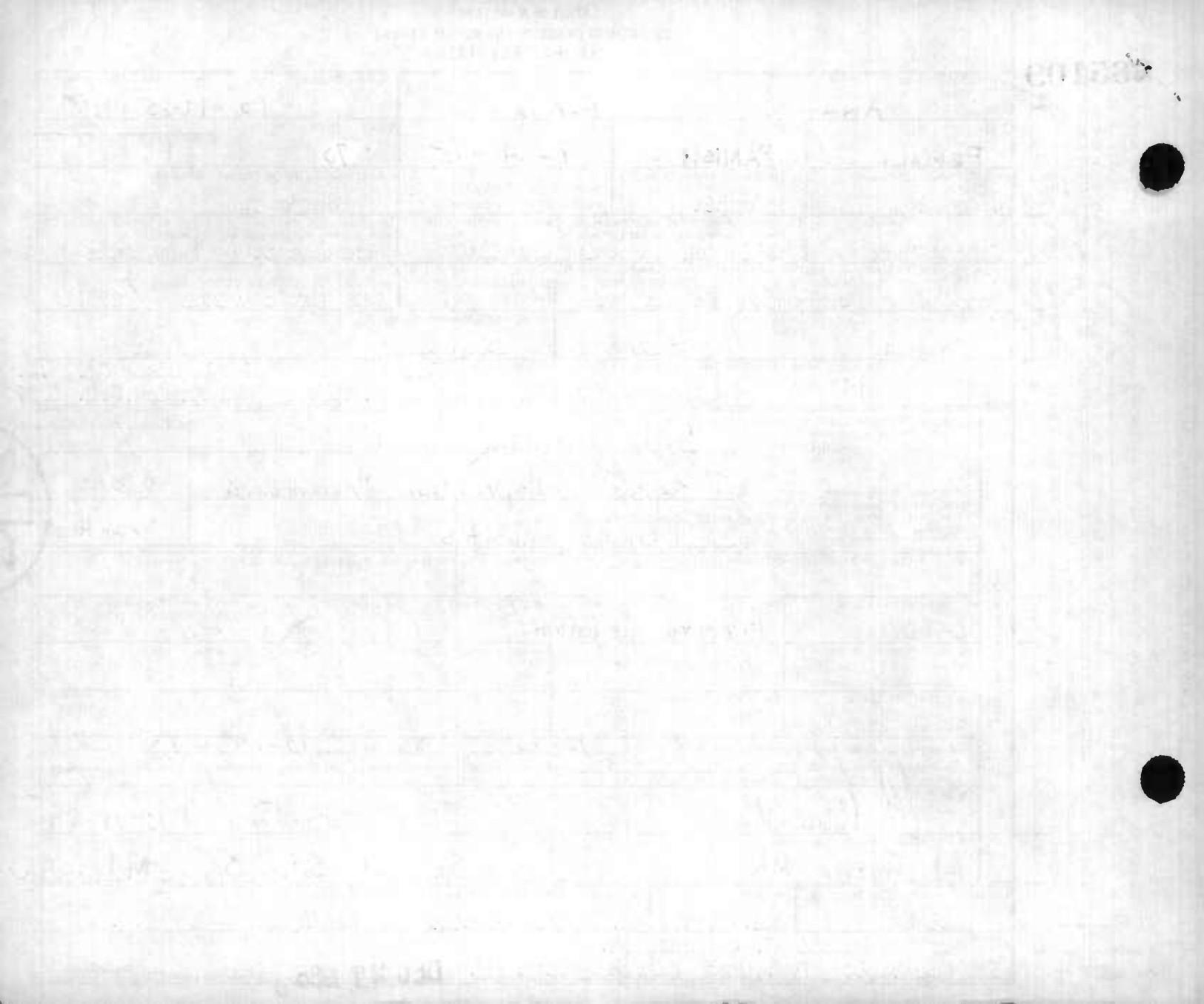
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, file it in the funeral director's file. Then please remove carbon paper. If you should be buried within 72 hours after death, should be reburied for use as the burial-transit permit. Then please remove carbon paper. Faxes should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 85 35097	
DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
ANA					GARCIA	12-17-85				11pm M	
SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)					
FEMALE		SPANISH		MONTH DAY YEAR 1 - 4 - 1934		81		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
YRS.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Colombia		Colombia				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Takoma Park		Washington Adventist Hospital		Housekeeper		Domestic					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Montgomery		Takoma Park		YES <input type="checkbox"/>		7620 Maple Avenue		20912	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Joaquin				Garcia		Sinfioriana				Pelaez	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
No		577-46-6668		Friend		1400 Quincy St., N.E.					
Fr. Francisco J. Sihuay						Washington, D.C. 20017					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio pulmonary Arrest</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Sepsis - Aspiration Pneumonia</i>										3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>Dermato myositis</i>										4 months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION <i>10-29-85</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Perforated Jejunum</i>				20a. AUTOPSY? <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>10-10</i> , 19 <i>85</i> , to <i>12-17</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>12-7</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>A.L. Frazier MD</i>		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>A.L. Frazier MD</i>		22e. ADDRESS <i>111 Spring St Silver Spring Md 20910</i>				22f. DATE SIGNED <i>12-18-85</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Dec. 20, 1985</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Olivet Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Washington</i>		23e. COUNTY		STATE	
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins, Jr.</i>		ADDRESS <i>500 University Blvd. West Silver Spring, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 27 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Francis J. Collins, Jr.</i>					



364058

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and should be detached for use as the burial transit permit. Then please remove carbon papers. Page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8535098		
								REG. NO.				
1. FOR STATE REGISTRAR		2d. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST			12-22-85		12:01 A			
JOSE ANTONIO				GARCIA								
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR			
MALE		HISP.		MONTH DAY YEAR			57 YRS		IF UNDER 24 HRS			
Sept 25 1928												
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
SPAIN		SPAIN		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Montgomery County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Kensington		4119 Pivers Mill Rd, Kensington								12b. KIND OF BUSINESS OR INDUSTRY Embassy of Venezuela		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4119 Pivers Mill Rd, Kensington. 20895			
MD		Montgomery		Kensington								
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			ADDRESS		LAST			
Salusciano			GARCIA	PILAR			Prieto					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT			Daughter		ADDRESS			
N/A		N/A		Rosa Tundo - Game			as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Cancer										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (he/she) attended the deceased from March 1985 to Dec. 22, 1985, that (I) (we) last saw the deceased alive on Dec. 22, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED		
22b. SIGNATURE <i>Thomas L. Sacks</i>		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		Dec. 23, 1985		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ADDRESS		22g. ADDRESS		22h. ADDRESS				
Thomas L. Sacks, Md.		2201 L Street, N.W.		Washington, DC								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Burial		Dec. 24, 1985		Gate of Heaven			Silver Spring		Montgomery		Md.	
24. FUNERAL DIRECTOR Fines/Rinaldi Funeral Home		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
							DEC 26 1985					
DHMH - 16 60M 7/84 (VRA 15, 4)												

20 NOV 1964  
JACOB M. MARSHALL

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 35099		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED			MONTH	DAY	YEAR	2b. HOUR		
Robert C. Gasch						<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12-14	1985	4 PM	4 PM		
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS) LAST BIRTHDAY			IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD			
M		W	02 03 1919			66 yrs.			MONTHS	DAYS	HOURS	MIN	12-14 1985 4 PM	
7e. BIRTHPLACE STATE OR FOREIGN		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		USA						Montgomery County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS U.S. Naval Security						
Silver Spring		Holy Cross Hospital			Engineer									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			14. FATHER'S NAME		
MD		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			4105 Isbell Street 20906			Clarence Gasch		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			15. MOTHER'S MAIDEN NAME						
Yes - Army		578-38-4810			Elena C. Gasch (Wife) Same as #13			Margaret Rohrback						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial Dici</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>COPD and Chronic myocardial Dici</i> DUE TO, OR AS A CONSEQUENCE OF (c)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i>														
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													TITLE (SPECIFY) ACTUAL SIGNATURE <i>John S. Rogers, M.D.</i>	M.D. Dep- MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT)		John S. Rogers, M.D.			ADDRESS 1919 Seminary Road Silver Spring, Md.			DATE SIGNED <i>Dec 14 1985</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 12/18/85			23c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood		COUNTY	STATE			
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781								25a. DATE REC'D. BY REGISTRAR DEC 17 1985		25b. REGISTRAR'S SIGNATURE <i>Actio. Frederic Pendell</i>				
BP														
DHMH 17 (VR A15 ME (5))														
20M 4/82														

12 different new - proposed products

365101

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3 WHICH SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												35100						
												REG. NO.						
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE KNOWN OF ESTI- DEATH MATED			2b MONTH DAY YEAR			2b HOUR			
			<i>Francis J. Geibel</i>						<input checked="" type="checkbox"/>			Dec. 22 1985			M			
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YR. MONTHS DAYS		8 IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			2d. HOUR		
M		W		Oct. 21 1915			70 yrs.						Dec. 22 1985			M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
NEW YORK			U.S.A.									Montgomery						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Rockville			15109 Rockcroft Rd									CPA			TPS 20853			
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
MD			Montgomery			Rockville						15109 Rockcroft Rd						
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
JOHN GEIBEL			LOUISA SPAHN															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
(YES, NO, OR UNKNOWN) WWII			091-07-8503			CARLEY L. GEIBEL			SAME AS 13 WIFE									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial D/S</i> DUE TO, OR AS A CONSEQUENCE OF															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF																		
(c) <i></i>																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																		
19a. DATE OF OPERATION <i>None</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?						
None												<input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																		
ACTUAL SIGNATURE <i>John S. Rogers</i>			TITLE (SPECIFY) M.D. D.P.M.									MEDICAL EXAMINER			DATE SIGNED <i>Dec. 22 1985</i>			
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 1919 SEMINARY RD., SILVER SPRING, MD.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 12/23/85			23c. NAME OF CEMETERY OR CREMATORIAL METROPOLITAN CREMATORY			23d. LOCATION CITY OR TOWN			COUNTY STATE						
CREMATION																		
24. FUNERAL DIRECTOR NAME			FRANCIS J. COLLINS, JR.									25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901												DEC 27 1985						

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0.078125

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0.0048828125

0.00244140625

0.001220703125

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death, age 4 may be extended by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/tranquill permit. Then please remove carbon papers. Pages 1 and 2 should be filed in a volume other than the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

ITEM NUMBER 4, PER PH. CALIF.

**CALL STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

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DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
FLORENCE A GEORGE-ADIS						12 - 31 - 85				9:30 P.M.	
1. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS					
F	White	MONTH DAY YEAR 5 9 1896	89	MONTHS	DAYS	HOURS	MIN.	YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH								
Greece	USA		Montgomery MD.								
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda	Suburban Hospital			Homemaker							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE							
Md.	Mont.	S.S.		3512 Olympic Street 20701							
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
FIRST Christos	MIDDLE	LAST Vitsas	FIRST Katherine	MIDDLE	LAST Poulos						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
None			212 74 8487			Deane George-Adis (Son)			Same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic congestive heart failure</i>									months		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atherosclerotic heart disease</i>									years.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-a											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
	P.M. 19										
21d. INJURY OCCURRED <input type="checkbox"/> WHILE WORK <input type="checkbox"/> NOT WHILE AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>19.82</u> , to <u>31 Dec.</u> , 19 <u>85</u> , that (II) (we) last saw the deceased alive on <u>31 Dec.</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											22c. DATE SIGNED
22b. SIGNATURE <i>Robert T. Kelley, Jr.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert T. KELLEY, MD</i>			22e. ADDRESS <i>8218 Wisconsin Ave</i>						<i>1 Jan 86</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION CITY OR TOWN	CITY OR TOWN		COUNTY		STATE			
Burial	1/3/86	Cedar Hill	Suitland	PG		Maryland					
24. FUNERAL DIRECTOR <i>Name</i> Hines/Rinaldi	25a. ADDRESS 11800 New Hamp.Ave. Silver Spring, Md.	25b. DATE REC'D. BY REGISTRAR <i>JAN 3 1986</i>	25b. REGISTRAR'S SIGNATURE <i>Ronald</i>								

3

345090

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 8. GIVE AGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGE 4 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												35102														
												REG. NO.														
1- STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR											
(TYPE OR PRINT)			Nasrolah			Ghias						<input checked="" type="checkbox"/> MONTH DAY YEAR			12/5/85 0156A											
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.					2c. DATE PRONOUNCED DEAD			2d. HOUR								
Male		Iran		MONTH DAY YEAR		64 yrs.		MONTHS DAYS		HOURS MIN.					December 12/5/1985 0156A											
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			WIDOWED			DIVORCED			9 BALTIMORE CITY OR COUNTY OF DEATH								
IRAN			IRAN			<input checked="" type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>			Montgomery								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Bethesda			Suburban Hospital									Administrative			Government			20852								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS														
MD			Montgomery			Rockville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			716 Harrington Rd														
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:			ADDRESS								
Hassan			Ghias			Maesome			No			son			IMMEDIATE CAUSE (a) myo cardiac infarction			716 Harrington Road Rockville, MD 20852								
DUE TO, OR AS A CONSEQUENCE OF												Asghar Ghias						ACUTE								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																										
{ (b) Arterio sclerotic cardiovascular Disease																		INDOP								
DUE TO, OR AS A CONSEQUENCE OF																										
(c)																										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?														
												<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21e. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21b. 12 5 1985			21c. collapsed with chest pain			21d. Home			21e. 716 Harrington Rd			Rockville			Montgomery			MD					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>			and in my opinion																				
ACTUAL SIGNATURE																										
EXAMINER'S NAME (TYPE OR PRINT)			Francis C. Myco			TITLE (SPECIFY)			M.D.			DEPT			MEDICAL EXAMINER			DATE SIGNED			12/5/85					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE											
Removal			12/9/85			Tehran			Tehran			Iran														
24. FUNERAL DIRECTOR NAME			ADDRESS			Wash., D.C. U.S.A.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRATION NUMBER														
Alexander S. Pope			2617 Pennsylvania Ave. S.E.						DEC 9 1985																	
DHMH - 17 (VR A15 ME (5))																										

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, fill in the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG. NO.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2d. HOUR						
MARY			Eleanor GIACOFI			12 12-6 -85			4:30 AM						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		WHITE		MONTH DAY YEAR			68			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
DISTRICT OF COLUMBIA		USA					Montgomery County, MD.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION <small>FOR MOST OF WORKING LIFE</small>			12b. KIND OF BUSINESS OR INDUSTRY								
SILVER SPRING		HOLY CROSS HOSPITAL		Homemaker											
13a. STATE <input checked="" type="checkbox"/> COUNTY <input type="checkbox"/> CITY OR TOWN												21658			
MARYLAND Queen Anne Queenstown												RT 1, Box 253A			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS								
William		MIDDLE N.	Lillian					M.							
LAST Hoyle		CARRICO		ADDRESS											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
No		579-09-2709			William J. Giacofci Same as 13										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Upper GI Hemorrhage															
DUE TO, OR AS A CONSEQUENCE OF (b) Gallbladder Cancer															
DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).															
19a. DATE OF OPERATION 11/24/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Abdominal pain + SEPSIS			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 11/23/85 19 to 12/6/85 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated <i>above, I did not see the body after death.</i>												22c. DATE SIGNED 12/6/85			
22b. SIGNATURE <i>Eric A. Orstian</i>												22d. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Eric A. Orstian		22f. ADDRESS 344 University Blvd W													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/9/85		23c. NAME OF CEMETERY OR CREMATORIAL St. Peters Church			23d. LOCATION CITY OR TOWN Queenstown, Queen Anne, Maryland			COUNTY		STATE			
24 FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd., Silver Spring, Md. 20901		25a. DATE REC'D. BY REGISTRAR ADDS DEC 13 1985			25b. REGISTRAR'S SIGNATURE <i>Francis J. Collins, Jr.</i>										



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - STATE  
REGISTRAR

10				8 5 3 5 1 0 4			
1. DECEASED NAME      FIRST: <u>Elizabeth</u> MIDDLE: <u>Drew</u> LAST: <u>Gilpatrick</u>				2d. DATE OF DEATH      MONTH: <u>12</u> DAY: <u>14</u> YEAR: <u>85</u>			
ELIZABETH DREW      GILPATRICK				26. HOUR: <u>9:30 PM</u>			
3. SEX: <u>Female</u> 4. RACE: <u>White</u> <u>Caucasian</u>				5. DATE OF BIRTH: MONTH: <u>01</u> DAY: <u>25</u> YEAR: <u>05</u>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): <u>Wash., D.C.</u>				6. AGE (IN YEARS LAST BIRTHDAY): <u>80</u> YRS.      IF UNDER 1 YEAR: MONTHS: <u>0</u> DAYS: <u>0</u> IF UNDER 24 HRS: HOURS: <u>0</u> MIN: <u>0</u>			
7b. CITIZEN OF WHAT COUNTRY?: <u>USA</u>				8. MARRIED: <input type="checkbox"/> NEVER MARRIED: <input type="checkbox"/> WIDOWED: <input checked="" type="checkbox"/> DIVORCED: <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH: <u>Bethesda</u>				9. BALTIMORE CITY OR COUNTY OF DEATH: <u>Montgomery</u>			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): <u>Fernwood House</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): <u>Homemaker</u>			
12b. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>				13a. STREET ADDRESS / ZIP CODE: <u>831 Dolley Madison Blvd. / 22101</u>			
14. FATHER'S NAME: FIRST: <u>Fred</u> MIDDLE: <u></u> LAST: <u>Drew</u>				15. MOTHER'S MAIDEN NAME: FIRST: <u>Alvina</u> MIDDLE: <u>L.</u> LAST: <u>Cutting</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): <u>No</u> 16b. SOCIAL SECURITY NO.: <u>224-48-4931</u>				17. INFORMANT: <u>David D. Gilpatrick, Same address as #13.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY ARREST</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>1 year</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>COARCTATION OF AORTA</u>				DUE TO, OR AS A CONSEQUENCE OF			
(c) <u></u>				DUE TO, OR AS A CONSEQUENCE OF			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>ACUTE OMEGATIS &amp; CHRONIC OMEGATIS</u>				↓			
19a. DATE OF OPERATION: <u></u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: <u></u>	20a. AUTOPSY? YES: <input type="checkbox"/> NO: <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES: <input type="checkbox"/> NO: <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING: <input type="checkbox"/> OR CONTRIBUTING: <input type="checkbox"/> CAUSE OF DEATH: <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY: HOUR A.M. <u></u> MONTH: <u></u> DAY: <u></u> YEAR: <u></u> P.M. <u>19</u>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): <u></u>		
21d. INJURY OCCURRED WHILE: <input type="checkbox"/> AT WORK: <input type="checkbox"/> NOT WHILE AT WORK: <input type="checkbox"/>				21e. PLACE OF INJURY: <u>AT HOME</u> STREET: <u></u> CITY OR TOWN: <u></u> COUNTY: <u></u> STATE: <u></u>	21f. LOCATION: STREET: <u></u> CITY OR TOWN: <u></u> COUNTY: <u></u> STATE: <u></u>		
22a. I certify that (I) (this hospital) attended the deceased from <u>12/14/85</u> to <u>12/14/85</u> , and that in (my) <u>I</u> (we) last saw the deceased alive on <u>12/14/85</u> , and that in (my) <u>I</u> (we) last opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not touch the body after death.				22b. SIGNATURE: <u>Carl J. Margolis</u>			22c. DATE SIGNED: <u>12/14/85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT): <u>Carl J. Margolis</u>				DEGREE: <u>M.D.</u> ATTENDING PHYSICIAN: <input checked="" type="checkbox"/> MEDICAL DIRECTOR: <input type="checkbox"/> STAFF PHYSICIAN: <input type="checkbox"/>			22e. DATE SIGNED: <u>12/14/85</u>
23a. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>				23c. NAME OF CEMETERY OR CREMATORIAL: <u>National Memorial Park</u>			23d. LOCATION: CITY OR TOWN: <u>Falls Church, VA</u> COUNTY: <u></u> STATE: <u></u>
24. FUNERAL DIRECTOR Joseph G. Gwier's Sons, Inc. 5130 <sup>AM</sup> Wisconsin Ave., NW, Washington, D.C. 20016				25a. DATE REC'D. BY REGISTRAR: <u>DEC 20 1985</u>			25b. REGISTRAR'S SIGNATURE: <u>John Garrison Pendleton</u>

999 TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 5 1 0 5

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME FIRST MIDDLE S. GILPIN				2d. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Frederic S. Gilpin				12 8 85	3 30 A.M.
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	Caucasian	NOV. 11 14 00	85	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	U.S.A.		Montgomery MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
SANDY SPRING	FRIENDS NURSING Home			12b. KIND OF BUSINESS OR INDUSTRY	
MD.	MONT.	SANDY SPRING	13a. STREET ADDRESS / ZIP CODE	GEN. CONSTRUCTION	
14. FATHER'S NAME	FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME			
CLARENCE LEA GILPIN	ROSE M. STABLER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	18015 Bentley Road		
(If Yes, give war or dates) NO	217-34-0484	F. LEA GILPIN	Sandy Spring, Md. 20860		
18. CAUSE OF DEATH (Enter only one cause per line for Part 1, Part 2 and Part 3) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> DUE TO, OR AS A CONSEQUENCE OF <i>Myocardial heart failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Diabetes CV Disease</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>Diabetes</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (the hospital) attended the deceased from 11/11/85 to 12/8/85, that (I) last saw the deceased alive on 11/11/85, and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (not) view the body after death.					
22b. SIGNATURE					
22c. DEGREE					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22e. DATE SIGNED
FRANCIS H. BARBER		BALT. WASH.CREMATORY			12/8/85
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION	
CREMATION		DEC. 8, 1985	BALT. WASH.CREMATORY	LAUREL	P. GEORGE
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
FRANCIS H. BARBER		DEC. 12, 1985		Francis H. Barber	

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be returned by the hospital or attending physician.  
 TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 18 is marked or item 19 shows any injury, or other traumatic event, the medical examiner should be informed.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8535106

REG. NO.

1-  
FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
ZENAIDA						GIRON	12	28	85	1120 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		
Female		Spanish		MONTH 10	DAY 11	YEAR 21	64	MONTHS YRS	MONTHS DAYS	HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Peru		Peru		<input checked="" type="checkbox"/> NEVER MARRIED	<input type="checkbox"/> DIVORCED	Montgomery						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Takoma Park		Washington Adventist Hospital		Homemaker								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		ZIP CODE		
MD		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8401 Manchester Rd		208 Bayfield Street #304 21250		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
LADISLO ADELINO				ROMERO	TRIGIDIA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS						
no		212-94-0788		FAUSTO GIRON 8401 MANCHESTER RD 55								
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Respiratory failure</u>												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>underdeveloped cell curvature</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Sepsis</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
<u></u>		<u></u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <u></u> CITY OR TOWN <u></u> COUNTY <u></u> STATE <u></u>								
22a. I certify that (I) (this hospital) attended the deceased from <u>12/14</u> , 19 <u>85</u> , to <u>present</u> , 19 <u></u> , that (I) (we) last saw the deceased alive on <u>12/14</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.												
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED						
Wilson MD		in lieu of								12/28/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		6525 Belcrest Rd Hyattsville MD								
Norton Elson												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN <u>Takoma Park</u> COUNTY <u>Maryland</u> STATE <u>MD</u>						
Burial		Dec. 31-1985		Date of Decease								
24. FUNERAL DIRECTOR NAME		Takoma Funeral Home.		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Robert L. Norton		254 Carroll St. N. W. D. C.		JAN 6 1986		John W. G. Rader						
BP _____												
DHMH - 16 60M 7/84 (VRA 15, 4)												

5. கால்வாய் முறை

22. (இ) கால்வாய் முறை நிறுப்பி

நிறுப்பி

கால்வாய் முறை நிறுப்பி தொடர்பு விவரம்

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The l retained by the hospital or attending physician.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please sign carbon copies Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial.

**IMPORTANT:** If Item 2 is marked or Item 18 shows any injury, or other unusual condition, the medical examiner must be notified or one

MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRATION

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG NO

3 35 0 7

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
MARGUERITE			Kaufman		GLASER	December 8, 1985				2:30a M		
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Female	White		January 2, 1891			94			IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington, DC		United States					Montgomery County			MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda			Carriage Hill-Bethesda						Housewife		at home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE	13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			
Maryland	Montgomery		Bethesda			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			9512-Kingsley Avenue 20814			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE	LAST		
			David	Joseph	Kaufman				-	Luchs		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No			034-18-6870			Anthony J. Glaser (Son) Same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY.												
IMMEDIATE CAUSE (a) Coronary Heart Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years												
DUE TO, OR AS A CONSEQUENCE OF (b) Alzheimer's Disease Years												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)						
			P.M. 19									
21d. INJURY OCCURRED  WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from October 26, 19 76, to December 8, 19 85, that (I) (we) last saw the deceased alive on December 7, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								12/8/85	
Jack Kreh, MD			1145-19th St., NW, Washington, DC 20036									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE	
Cremation			Dec. 8, 1985		Lee's Crematory			Washington, District of Columbia				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
J.Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002						DEC 17 1985			Gloria Kreh			

BR \_\_\_\_\_

xx  
1. W.W.Iee, a son of Goro G.O.3-0-455 G., AF, War., DCSOOS, 177-105P #4., W, Washington, DC 2003  
Gardening Dec. 8, 1982, Inc. a Corporation  
Lawnmower, District of Columbia  
1000 West, 1st Street, N.W.  
Washington, DC 20004  
No  
to  
Q34-T8-9830 Although J.G. (son) same as T8  
Years  
Vesperine's Disease  
Gordonia Heart Disease  
Years  
no  
Days  
Waltzing  
Hopping  
Moultswear  
Begleas  
Q515-Himself (various SCG)  
Hope  
-  
Kangaroo  
Cats  
-  
Nest  
-  
Mallory  
Waltzing  
SCG  
United States  
Washington, DC  
Leaves  
Housewife  
at home  
Decemper 8, 1982  
Developers  
xx

xx  
1. W.W.Iee, a son of Goro G.O.3-0-455 G., AF, War., DCSOOS, 177-105P #4., W, Washington, DC 2003  
Gardening Dec. 8, 1982, Inc. a Corporation  
Lawnmower, District of Columbia  
1000 West, 1st Street, N.W.  
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Gordonia Heart Disease  
Years  
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to  
Q34-T8-9830 Although J.G. (son) same as T8  
Years  
Waltzing  
Hopping  
Moultswear  
Begleas  
Q515-Himself (various SCG)  
Hope  
-  
Kangaroo  
Cats  
-  
Nest  
-  
Mallory  
Waltzing  
SCG  
United States  
Washington, DC  
Leaves  
Housewife  
at home  
Decemper 8, 1982  
Developers  
xx

006141

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 4 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 35108					
1- STATE REGISTRAR			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR 12 25 85									2b. HOUR 6 35 M					
1. DECEASED NAME (TYPE OR PRINT) HARRIET M. GLASSMAN						6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.			7. IF UNDER 1 YR. MONTH DAYS HOURS MIN.			2c. DATE ESTIMATED DEATH MATED MONTH DAY YEAR 12 25 85			2d. HOUR 6 35 M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jul 31, '17		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery			MD.		
10. CITY OR TOWN OF DEATH Gaithersburg			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 19001 Glendower Road									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE New Jersey			13b. COUNTY Atlantic		13c. CITY OR TOWN Ventnor		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 7301 Marshall Avenue			98406				
14. FATHER'S NAME FIRST Phillip			MIDDLE		LAST Marks		15. MOTHER'S MAIDEN NAME FIRST Bessie			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			17. INFORMANT ADDRESS Ventnor, N.J. 08406			LAST Weisman	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cardio Respiratory arrest									18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.			DUE TO, OR AS A CONSEQUENCE OF  (b) metastatic carcinoma of DUE TO, OR AS A CONSEQUENCE OF  (c) The Breast.														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an			Autopsy <input type="checkbox"/>			Inspection <input checked="" type="checkbox"/>			Inquiry <input type="checkbox"/>			and in my opinion					
death resulted from: Natural causes <input checked="" type="checkbox"/>			Accident <input type="checkbox"/>			Suicide <input type="checkbox"/>			Homicide <input type="checkbox"/>			Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE JOHN F. TAUBER			M.D.			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER			DATE SIGNED 12-26-1985					
EXAMINER'S NAME (TYPE OR PRINT) JOHN F. TAUBER, M.D.			ADDRESS 8218 Wisc. Ave., Bethesda, Md.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-27-1985			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Sharon Cemetery			23d. LOCATION CITY OR TOWN Springfield, Pa.			COUNTY STATE					
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike			ADDRESS Rockville, Md.			25a. DATE REC'D. BY REGISTRAR DEC 30 1985			25b. REGISTRAR'S SIGNATURE Julie Danzansky								

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Robert G. Johnson & Son  
Book Publishers  
1000 Franklin Street  
Seattle, Wash.



14.000

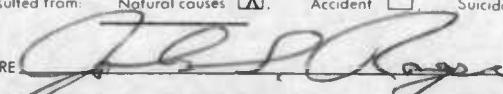
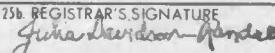
003053

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-1 RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1, 2, AND 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 35109

1 - STATE REGISTRAR			2a. DATE KNOWN X MONTH DAY YEAR OF ESTI- DEATH MATED <input type="checkbox"/> 12/26 19 85 P.M. HOUR 8:00											
1. DECEASED NAME (TYPE OR PRINT) <b>Laura O. Godfrey</b>			MIDDLE			LAST			2b. DATE KNOWN X MONTH DAY YEAR OF ESTI- DEATH MATED <input type="checkbox"/> 12/26 19 85 P.M. HOUR 8:00					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Apr. 2, 1888</b>		6. AGE (IN YEARS (LAST BIRTHDAY) <b>97 YRS.</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>			10. DATE PRONOUNCED DEAD <b>12/26 19 85 P.M.</b>					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>14000 Castle Boulevard, #200</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		
13a. STATE <b>Florida</b>			13b. COUNTY <b>Broward</b>		13c. CITY OR TOWN <b>Hollywood</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>2010 Fillmore Street #401</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>John August Oscarlund</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Friedericka Heise</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>N/A</b>			16b. SOCIAL SECURITY NO. <b>173-05-6656 D</b>			17. INFORMANT ADDRESS <b>Laura DeFonso-daughter-S.S. Md. 20904</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>chronic myocardial disease.</b> DUE TO, OR AS A CONSEQUENCE OF (c)														
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>None</b>														
19a. DATE OF OPERATION <b>None</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>None</b>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE  EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>														
TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER 1919 Seminary Road ADDRESS Silver Spring, Montgomery County, Md.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>12-31-1985</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Lee's Crematory</b>			23d. LOCATION CITY OR TOWN <b>Washington, D.C.</b>			23e. COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi Funeral Home</b>			24b. ADDRESS <b>11800 N.H. Ave., Silver Spring, Md.</b>			24c. DATE REC'D. BY REGISTRAR <b>DEC 31 1985</b>			24d. REGISTRAR'S SIGNATURE 					

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8535110

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Anna Ihong					Gondos	12-20-85				6:55 M	
3. SEX	4. RACE	5. DATE OF BIRTH									
Female	White	MONTH DAY YEAR 6-22-10									
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH							
Hungary	U.S.A.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Montgomery							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Holy Cross Hospital					Interior Decorator					Private
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?					13e. STREET ADDRESS / ZIP CODE			
Maryland	Mont.	Chevy Chase	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					8423 Donnybrook Drive			20815
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
Jacob		U/K	Havas	Irene					LAST Bleier		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES GIVE WAR OR DATES)		17. INFORMANT					ADDRESS			
NO	N/A		Dr. Bela Gondos					Same as 13a to 13e			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Distress</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 min											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Breast Cancer</u>											Years
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.a.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <u>12-20</u> , 19 <u>81</u> , to <u>12-22</u> , 19 <u>81</u> , that (I) <input checked="" type="checkbox"/> did not saw the deceased alive on <u>12-20</u> , 19 <u>81</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Phillip W. Poth</u>		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED 12-20-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		831 University Blvd. East Suite 32 Silver Spring MD 20903							
Phillip W. Poth MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		12/22/85		Judean Gardens		Olney		Mont.		Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Ives-Pearson Funeral Homes, FC, Va.				DEC 24 1985 Julie Garrison-Roselle							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then attach the burial/transit permit to the death certificate and file with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, either traumatic or non-traumatic event, the medical examiner must be notified or police called.

882023



LIBRARY



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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5

3 5

1 1

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
Oswald J. Gnotta						12-30-85				9 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		White		MONTH	DAY	YEAR	75	YEARS	MONTHS	DAYS	HOURS	MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Wash., D.C.		USA						Montgomery MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY							
Silver Spring		Holy Cross Hospital		Waiter		Hotel							
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE					
---		V		Washington, DC				1330 New Hampshire Ave, NW/20036					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME								
Herman		---	---	Gnotta	Marina		---		LAST				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b SOCIAL SECURITY NO		17. INFORMANT		ADDRESS					
Yes		WW II		579-03-3866		Angela G. Day, 11001 Drumm Ave, Kensington, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ABRASION Pneumonia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Stroke</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d INJURY OCCURRED  WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____									
22a. I certify that (I) (this hospital) attended the deceased from Jan. 16, 1984, to Dec. 30, 1985, that (II) (we) last saw the deceased alive on Dec. 30, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (I) did not view the body after death.													
22b. SIGNATURE _____ DEGREE _____													
22c. DATE SIGNED <u>12/31/85</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>1/3/86</u>		23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN <u>Silver Spring, MD</u>		23e. ADDRESS <u>1980 Georgia Ave Silver Spring, MD</u>					
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME <u>ACROSS</u> 5130 Wisconsin Ave, NW, Washington, D.C. 20016						25a. DATE REC'D. BY REGISTRAR <u>JAN 3 1986</u>		25b. REGISTRAR'S SIGNATURE					

999999 TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be

BP  
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 4 may bewith the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicalDHMH - 16-60M 7-184  
(VRA 15, 4)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial transit permit. Then please remove with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other treatment.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other trauma at the time of death, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 6535110											
1. FOR STATE REGISTRAR			1. DECEASED NAME FIRST Fannie MIDDLE GORDON LAST			2a. DATE OF DEATH MONTH DECEMBER YEAR 1985			2b. HOUR 11:25 P.M.		
1. DECEASED NAME (TYPE OR PRINT)			1. DECEASED NAME FIRST Fannie MIDDLE GORDON LAST			2a. DATE OF DEATH MONTH DECEMBER YEAR 1985			2b. HOUR 11:25 P.M.		
3. SEX Female			4. RACE white			5. DATE OF BIRTH DECEMBER 25, 1900			6. AGE (IN YEARS LAST BIRTHDAY) 84		
7a. BIRTHPLACE (STATE OR FOREIGN) LATVIA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery COUNTY MD.		
10. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL			12a. USUAL OCCUPATION HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a. STATE MARYLAND			13b. CITY OR TOWNSHIP MARLOW HEIGHTS			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 2900 ST. CLAIR DRIVE 20031		
14. FATHER'S NAME JACOB			15. MOTHER'S MAIDEN NAME RACHEL								
16. WAS DECEASED EVER IN U.S. ARMED FORCES? NO			16b. SOCIAL SECURITY NO. 577-84-3024			17. INFORMANT MRS. NEOME G. BERG, 20915 WOLF STREET FORT WASHINGTON, MARYLAND			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 d		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic shock			DUE TO, OR AS A CONSEQUENCE OF (b) pneumonia						1 d		
			DUE TO, OR AS A CONSEQUENCE OF (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART Ia Renal failure, multiple strokes											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I or this hospital) attended the deceased from 12/23/85 to 12/23/85, that (we) last saw the deceased live on 12/23/85, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. We did not view the body after death.											
22b. SIGNATURE Peter B. Sherer			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/23/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter B. Sherer MD			22e. ADDRESS 3947 Ferrara Dr. Wheaton MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/25/1985			23c. NAME OF CEMETERY OR CREMATORIUM HEV SHOLOM PALMUD TORAH CONGREGATION CEMETERY			23d. LOCATION CITY OR TOWN WASHINGTON COUNTY STATE D. C.		
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.						25a. DATE REC'D. BY REGISTRAR DEC 30 1985			25b. REGISTRAR'S SIGNATURE Julie Davidson Pendleton		
DHMH - 16 60M 7/84 (VRA 15, 4)											

8-1069

WILLIAMSON  
MOTOR VEHICLE

Interpretation 88-08-11

#13a, 17, FilmG610 12/31/85 kam

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 5 1 4

347089

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>DOROTHY E</i>	MIDDLE	LAST <i>Gould</i>	2a DATE OF DEATH MONTH YEAR <i>12/4/85</i>	MONTH	DAY	YEAR	2b HOUR <i>7:25 AM</i>			
3. SEX			4. RACE	5. DATE OF BIRTH MONTH DAY YEAR <i>Nov 7, 1904</i>			6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
<i>Female</i>			<i>Caucasian</i>										
7a BIRTHPLACE COUNTRY <i>Penna.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Mont.</i>			MD.	
10. CITY OR TOWN OF DEATH <i>BETHESDA</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>SUBURBAN</i>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Clerk/Stenographer</i>			12b KIND OF BUSINESS OR INDUSTRY <i>Federal Aviation Agency</i>				
13. STATE <i>Maryland</i>			13b. COUNTY <i>Mont.</i>	13c. CITY OR TOWN <i>Rockville</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>10099 Rollins Avenue #08</i>			20852		
14. FATHER'S NAME FIRST <i>Harvey</i>			MIDDLE <i>R.</i>	LAST <i>Gould</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Emma</i>			ADDRESS <i>Macguire Kensington, Maryland</i>			LAST <i>Weed</i>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>			16b SOCIAL SECURITY NO. <i>WW II 172 09 5403</i>			17. INFORMANT <i>Mrs. Marjorie MacGuire</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>respiratory arrest</i>			DUE TO, OR AS A CONSEQUENCE OF (b) <i>primary atypical pneumonia</i>						6 days				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>new onset seizure disorder</i>													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) new onset seizure disorder							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <i>Dec. 4 1985</i>			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital attended the deceased from <i>1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I will later disinter and view the body after death.)													
22b. SIGNATURE <i>6 Peter Pushkas</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			24. DATE SIGNED <i>Dec. 4, 1985</i>				
22c. ADDRESS <i>1150 Old Georgetown Rd.</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Dec 7, 1985</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Crestview Mem'l Park</i>			23d. LOCATION CITY OR TOWN <i>Pine Township, Mercer, Penna</i>			25a. DATE REC'D. BY REGISTRAR <i>Dec 9 1985</i>			
24. FUNERAL DIRECTOR NAME <i>Ives-Pearson Funeral Homes, Arlington, Va. 22201</i>			ADDRESS								REGISTRAR'S SIGNATURE <i>John Bender Jr.</i>		

10. HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18b is marked, or if item 18a is marked, or if item 22a is marked, the medical examiner must be notified.

*advertisements* 1898. 343

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. If the funeral director, page 3  
retd by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be retained for use at the burial/transit period. Then please remove carbon copies, pages 1 and 2, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.  
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certifying physician must sign this section.

365107

1 - STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Ellie	MIDDLE Gay	LAST Graves	2a DATE OF DEATH December 22, 1985	MONTH YEAR	DAY	2b HOUR 6:40 P.M.				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH August 14, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 93		7. IF UNDER 1 YEAR MONTHS YRS					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County		10. IF UNDER 24 HRS HOURS MIN.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill of Bethesda		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Banker		12b. KIND OF BUSINESS OR INDUSTRY Banking		MD.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9220 Le Velle Drive 20815	
14. FATHER'S NAME FIRST John			MIDDLE Floyd	LAST Gay	15. MOTHER'S MAIDEN NAME FIRST Julia			MIDDLE Elmetta	LAST Teague				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. N/A			17. INFORMANT (Daughter) Ann Graves Gagarin			ADDRESS 9220 Le Velle Drive Chevy Chase, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH STAT.							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>cardiac arrest</u> (c) <u>thromboembolism</u>						STAT.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (we) attended the deceased from JULY 7, 1965, to DEC 22, 1985, that (I) (we) last saw the deceased alive on DEC 22, 1985, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Robert S. Poole</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED December 23, 1985				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert S. Poole M.D.			22e. ADDRESS Washington, D.C. 20008			4501 Connecticut Avenue N.W. #322							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 31, 1985			23c. NAME OF CEMETERY OR CREMATORIUM Myrtle Hill Cemetery			23d. LOCATION CITY OR TOWN Rome, Georgia				
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, ADDRESS P.A. 7557 Wisconsin Avenue, Bethesda, Maryland													
25b. REGISTRAR'S SIGNATURE <u>DEC 27 1985</u>													



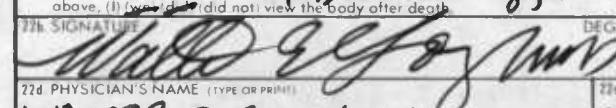
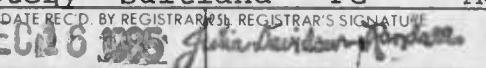
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 5 1 1 0

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Margaret Virginia Graves				Dec 11, 1985 10:00AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR	
				Aug 31, 1910	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE IN YEARS (LAST BIRTHDAY) MONTHS DAYS HOURS MIN.	
				75 YRS	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
13a. STATE Md		13b. COUNTY PG		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance	
		13c. CITY OR TOWN Clinton		12b. KIND OF BUSINESS OR INDUSTRY USG OV'T	
14. FATHER'S NAME George		MIDDLE Fitch		15. MOTHER'S MAIDEN NAME Agnes	
				LAST Cady	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-20-7796		17. INFORMANT John Joseph Graves SAME As #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>CARDIAC ARREST</b> MMED			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>			
		(c) _____			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 17 SEPT 85 to 11 DEC 85, that (I) (last saw the deceased alive on 4 DEC 19 85 and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death)					
22b. SIGNATURE  DEGREE					
22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. ADDRESS 2309 SHOREFIELD RD WHEATON MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 13 Dec 85	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		23d. LOCATION TOWN Suitland
					COUNTY PG
24. FUNERAL DIRECTOR NAME Robert E. Wilhelm Funeral Home		ADDRESS Suitland, Md.	25a. DATE REC'D. BY REGISTRAR 16 DEC 1985		25b. REGISTRAR'S SIGNATURE 

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that this certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then page 3 may be carboncopied. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, interment, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20-2268



364163

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
Mary Mary E Elizabeth Greene				12/12/85	85	1130 AM						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)						
Female		White		Month March Day 22 Year 1900		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Virginia		USA				Montgomery MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION			13b. KIND OF BUSINESS OR INDUSTRY					
Rockville		Brody Grove Adventist Hospital		Housewife			Home					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS / ZIP CODE						
West Virginia		Berkeley		Martinsburg		703 Porter Avenue 25401						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
		William		Jenkins	FIRST	Jackie	MIDDLE	Emmons				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT				ADDRESS				
No		232-26-7342		Mary Lou Nicewarner				312 S. Illinois Ave Martinsburg, WV 25401				
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>None</i>			
(b) <i>Congestive Heart Disease</i>									<i>None</i>			
(c) <i>Arteriosclerosis</i>									<i>None</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>1981</u> , to <u>1987</u> , that (I) last saw the deceased alive on <u>1981</u> , and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Thos G. Ward</i> DEGREE <i>MD</i>												
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22c. DATE SIGNED <i>12/13/85</i>												
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <i>6116 Belmont Bethesda 20817</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Dec. 15, 1985		23c. NAME OF CEMETERY OR CREMATORIY Rosedale Cemetery			23d. LOCATION CITY OR TOWN Martinsburg		COUNTY Berkeley STATE WV			
Burial												
24. FUNERAL DIRECTOR NAME <i>Charles M. Brad</i>		ADDRESS <i>327 W. King St POBox 821, Martinsburg, WV</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 20 1985</i>		25b. REGISTRAR'S SIGNATURE <i>J. Anderson</i>						
Brown Funeral Home												

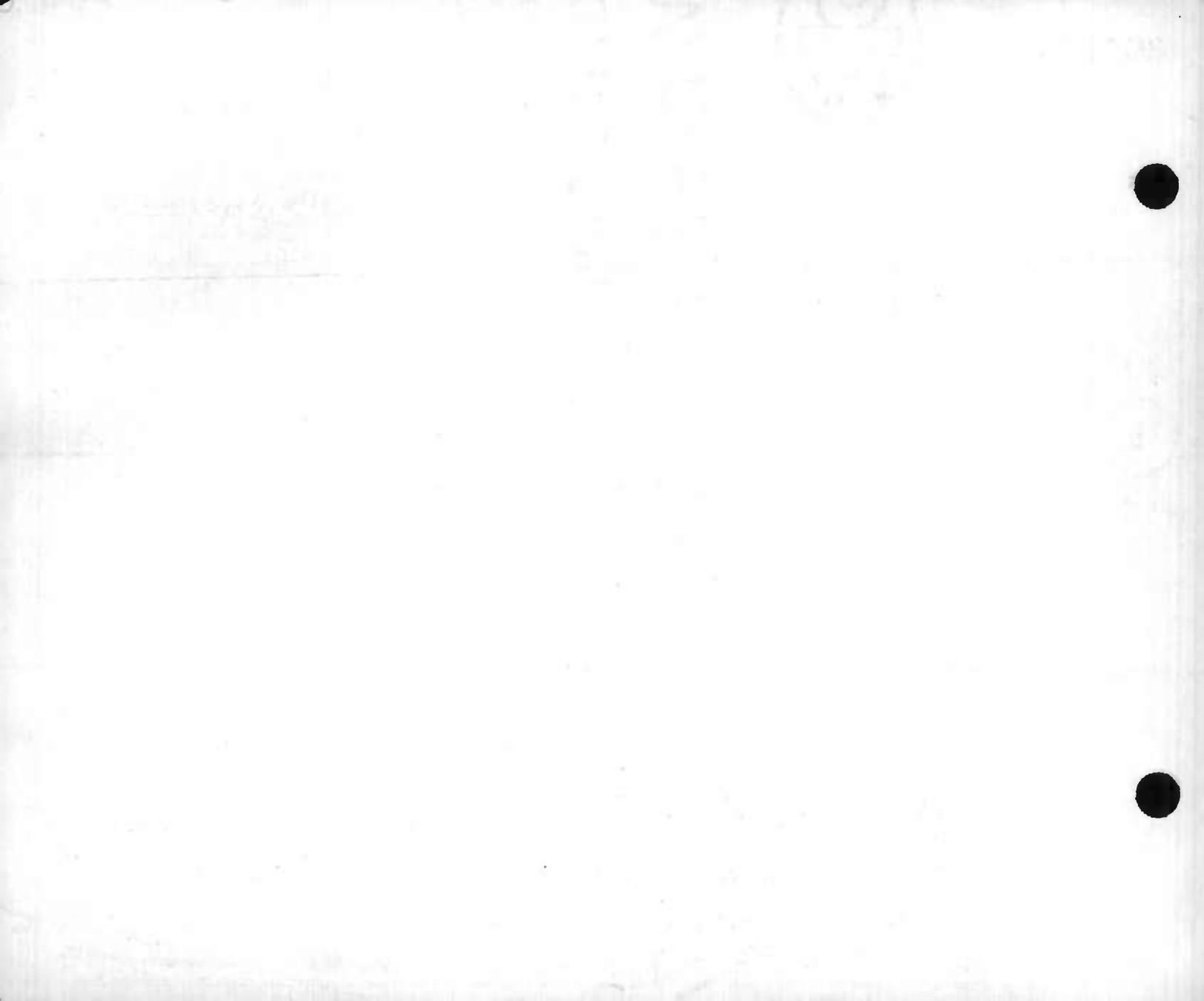
executed within 24 hours of death. Page 4 may be

relinquished by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death.

With the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

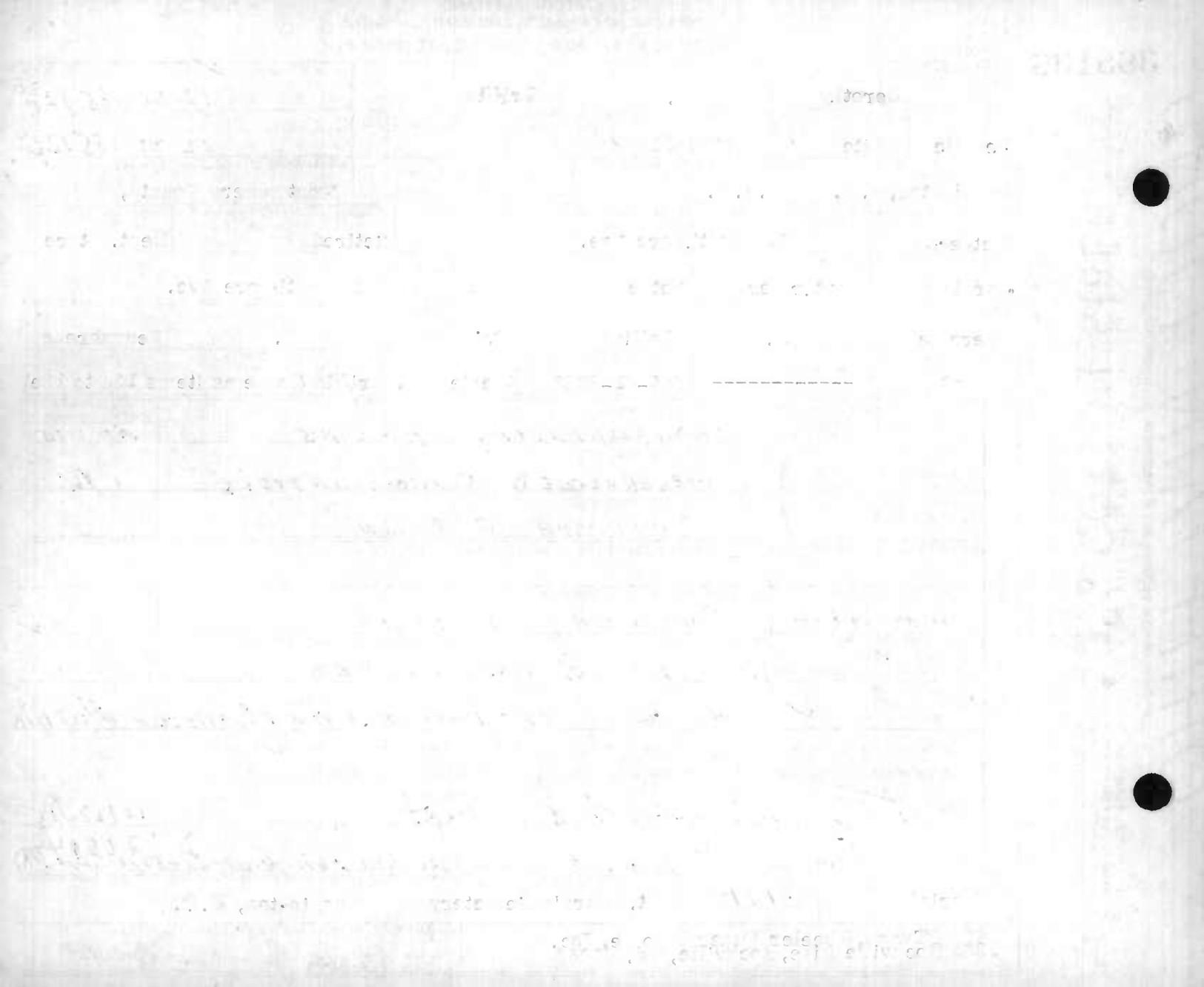
IMPORTANT: If item 21 is marked or if item 18 shows any injury or other traumatic event, the medical consumer must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PH-100. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETAINED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 5 35 1 8						
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH DAY YEAR		2b. HOUR				
			Dorothy M. Griffith						<input type="checkbox"/>			12 20 19 85		12:30 PM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR		2d. HOUR	
Female		White		7 30 1911		74 yrs.						12 20 19 85			12:30 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		X NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH			Montgomery County, MD.							
Washington, D.C.		U.S.A.																
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Bethesda			5219 Baltimore Ave.						Retired			Dept. Store						
11. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS								
Maryland			Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			5219 Baltimore Ave. 20843								
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
Jerome A. Collins			Johanna S. Feusahrens															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 577-01-8223			17. INFORMANT ADDRESS												
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			CARIBRESPRATORY FAILURE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH AC-UTD												
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:			DUE TO, OR AS A CONSEQUENCE OF															
(b)			GENERALIZED CARCINOMATOSIS			1 YR.												
(c)			CARCINOMA OF COLON															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																		
19a. DATE OF OPERATION May 1984			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of colon			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR 12:34 P.M. 12 20 19 85			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) DIED IN BED												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5219 Baltimore Ave Bethesda Maryland												
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			TITLE (SPECIFY) Francis C. Mayo M.D. Dept. MEDICAL EXAMINER			DATE SIGNED 12/22/85												
ACTUAL SIGNATURE																		
EXAMINER'S NAME (TYPE OR PRINT)																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/24/85			23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery			23d. LOCATION Cemetery COUNTY STATE Washington, D.C.									
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852						25a. DATE REC'D. BY REGISTRAR DEC 27 1985			25b. REGISTRAR'S SIGNATURE Leah Davidson Pendleton									
BP																		
DHMH - 17 (VR A15 ME (5)) 30M 7/73																		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

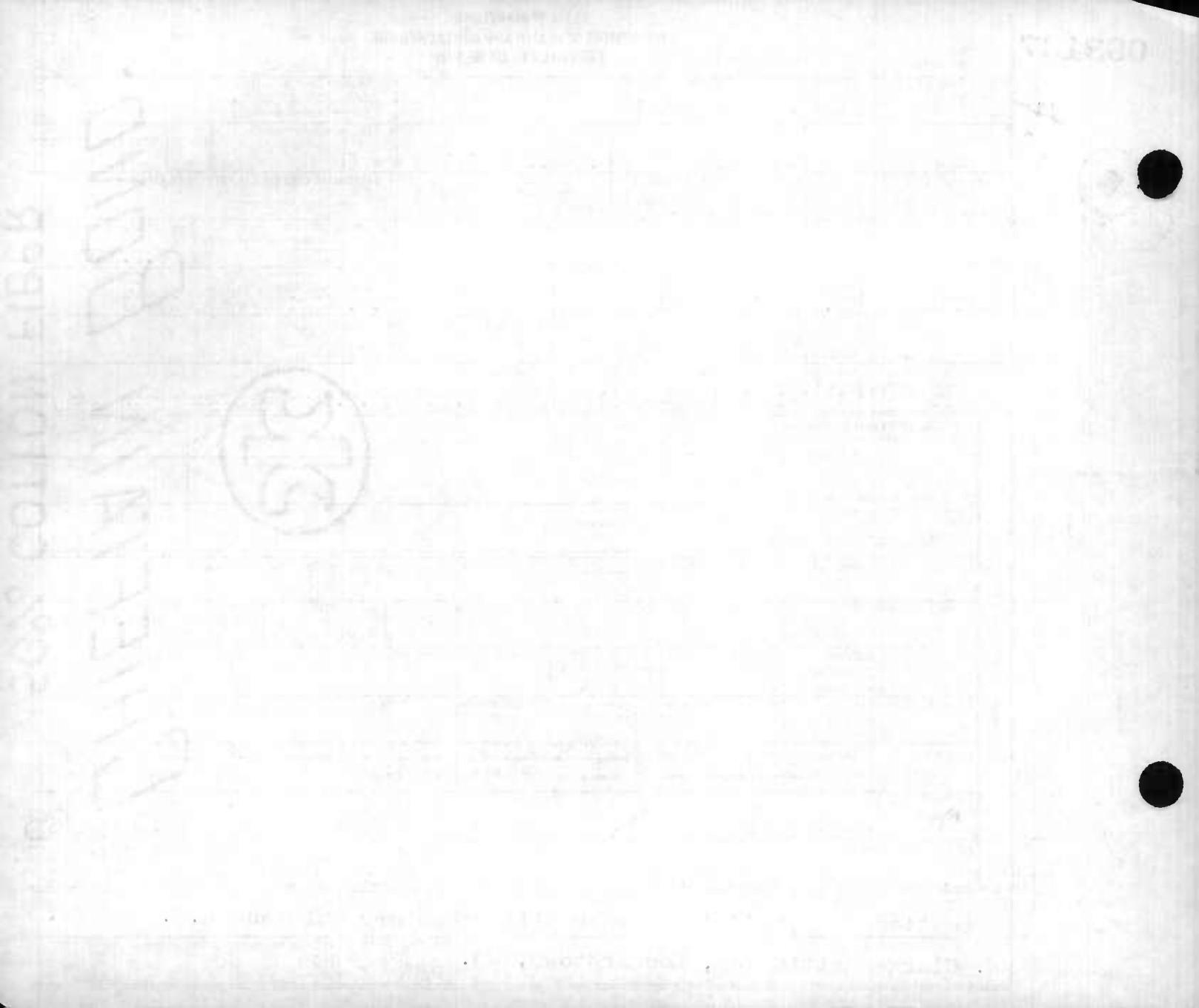
008137

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 35119

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2d HOUR	a		
EMERSON PETER GROFF						DECEMBER 26 1985			6:50		m		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE		CAUCASIAN		MONTH DAY YEAR AUGUST 20 1917		68 yrs			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.	
NEW YORK		UNITED STATES		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					MONTGOMERY				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
BETHESDA		NAVAL HOSPITAL		RETIRING			U.S. NAVY						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
MARYLAND		ST. MARY'S		LEXINGTON PK				P.O. BOX 162		20653			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST				
		EARL	EMERSON	GROFF			LENA	VOSBURGH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
YES		1941-1961		169-05-9186		NORMA B. GROFF, P.O. Box 162, Lexington Park, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC SMALL CELL CARCINOMA OF THE LUNG</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 14, 1985, to DECEMBER 26, 1985, that (I) (we) last saw the deceased alive on DECEMBER 26, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>M. Pierdenock MD</u>		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>27 Dec 85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814							
M. PIERDENOCK, LCDR, MC, USNR													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY					
Cremation		12/28/85		Cedar Hill Crematory		Suitland P.D.		Md.					
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley</u>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
		JAN 6 1986											



347090

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 5 1 2 0

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH MONTH DAY YEAR	DAY	YEAR	2d. HOUR 15 <sup>14</sup>	
EMIL C. GROSS										
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 75	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.					
Male	Cau.	5 27 1910	YRS							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New Jersey</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County, MD</i>							
10. CITY OR TOWN OF DEATH <i>Rockville</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Hebrew Home Greater Washington Accountant</i>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>United Fund</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Accountant</i>							
13a. STATE <i>Md.</i>	13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Rockville</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>6131 Montrose Rd., 20852</i>						
14. FATHER'S NAME FIRST <i>ALEXANDER</i>	MIDDLE	LAST <i>GROSS</i>	15. MOTHER'S MAIDEN NAME FIRST <i>HATTIE</i>	MIDDLE	<i>LIEBERMAN</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>N/A</i>	16b. SOCIAL SECURITY NO. <i>070-07-9649</i>	17. INFORMANT <i>Washington, D.C. 20015</i>								
18 CAUSE OF DEATH (Enter only one cause per line for 18, (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stopping the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <i>12 years</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Influenza</i>										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) saw the deceased alive on Nov 30 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from Nov 30 1985, to Dec 2 1985, that (I) (we) lost saw the deceased alive on Nov 30 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Robert Bayer</i>	DEGREE <i>M.D.</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>12-2-85</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ROBERT BAYER</i>	22e. ADDRESS <i>5415 W. CEDAR LN BETHESDA, MD</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>12/5/85</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Warrensville Cemetery</i>	23d. LOCATION CITY OR TOWN <i>Beachwood, Ohio</i>	COUNTY	STATE					
24. FUNERAL DIRECTOR NAME <i>DANZANSKY-GOLDBERG MEMORIAL CHAPEL</i>	ADDRESS <i>1170 Rockville Pike; Rockville, Md. 20852</i>	25a. DATE REC'D. BY REGISTRAR <i>DEC 9 1985</i>	25b. REGISTRAR'S SIGNATURE <i>Julia Davidson, R.N.</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed later by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 5 1 2 1

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Fee			Grunfeld			12 24 85			1327 M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		Caucasian		12 15 20			65				
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Germany		USA.					Montgomery Co.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda		SUBURBAN HOSPITAL		Housewife			Own Home				
USUAL RESIDENCE (IF HAVING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STREET ADDRESS / ZIP CODE					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			66-10 Thornton Place			99999		
New York	Queens	Regal Park-Queens									
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Shalom		Brenner		Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
no		124 24 2834		Isidore Grunfeld (husband) See #13 above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Cardiac Arrest											
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction											
DUE TO, OR AS A CONSEQUENCE OF (c) Severe coronary artery disease											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 13/24/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		Old Georgetown Rd., Bethesda, Md.							
William Fullner M.D.											
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		Dec. 28, 1985		Mt. Hebron Cemetery		Flushing,		New York			
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR					
Ives-Pearson Funeral Homes, Arlington, Virginia						25b. REGISTRAR'S SIGNATURE J.C. Eason Jr.					

NO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that this death certificate be executed within 24 hours after death. Page 4 may be

5 TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please sign the copy you keep. Page 1 and 2 should be held within 72 hours after death.  
REMOVED  
BY THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE prior to burial. (Do not remove)  
IMPORTANT: If Item 21 is marked or No. 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.BP  
DHMH - 16-60M 7-1984  
(VRA 15-4)

99999

100% cotton

100% cotton

100% cotton  
100% cotton  
100% cotton

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. RETAIN PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												35122
												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b HOUR
Satish					Gupta	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12	20	1985	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
Female	Indian	July 12, 1944	41 yrs.			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12	20	1985	3:06P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
India		India						Montgomery County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Takoma Park		Washington Adventist Hospital			Housewife			own home				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
Maryland		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12605 Montclair Drive		20904		
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
Amar				Nath		Lila				Wati		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input type="checkbox"/> N/A		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT		ADDRESS						
		218-80-5390		Balraj Gupta-husband- (same as 13e )								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cranio cerebral trauma</u> DUE TO, OR AS A CONSEQUENCE OF 8/20 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
					<input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <del>XX</del> MONTH DAY YEAR 2 P.M. 12 20 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) Driver in auto/auto impact							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road			21f. LOCATION STREET CITY OR TOWN New Hampshire Ave, Silver Spring, Mont., MD.			COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an death resulted from <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE <i>Ronald Smith</i>												
EXAMINER'S NAME (TYPE OR PRINT)		Thomas D. Smith, M.D.			ADDRESS			TITLE (SPECIFY) M.D. Acting Chief MEDICAL EXAMINER				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <input type="checkbox"/> Cremation		23b. DATE Dec. 22, 1985			23c. NAME OF CEMETERY OR CREMATORY Balt. Washington Crematory			23d. LOCATION Laurel Prince Georges Md.				
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home		11800 N.H. Ave., Silver Spring, Md.			25a. DATE REC'D. BY REGISTRAR DEC 23 1985			25b. REGISTRAR'S SIGNATURE <i>Jane Wilson-Parker</i>				
BP												
DHMH - 17 (VR A15 ME (5))												

300 CODE OF THE ESTATE

28-12-030

003054

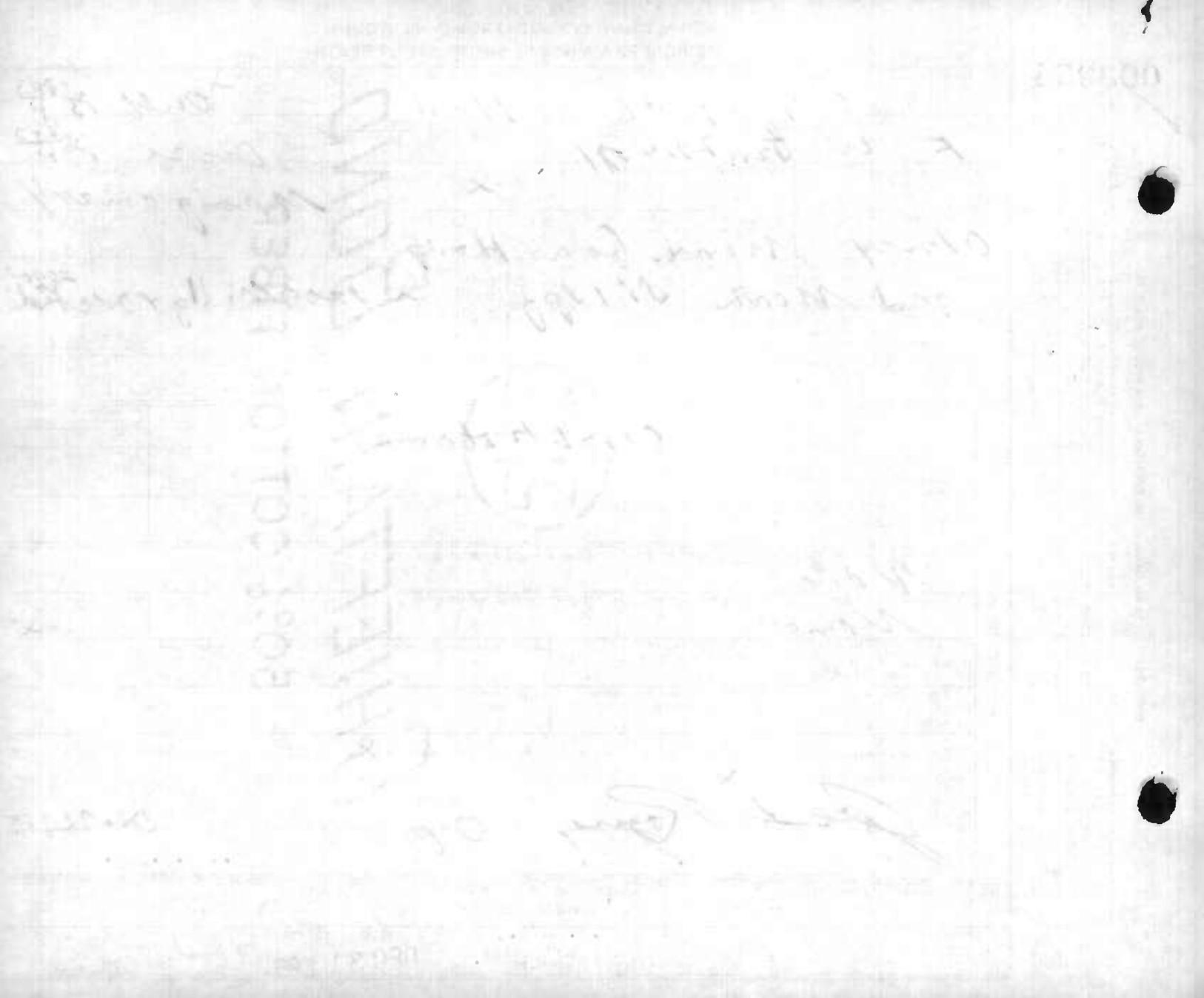
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1 AND 3 TO THE FUNERAL DIRECTOR.  
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

35123

REG. NO.

1 - STATE REGISTRAR		2a. DATE KNOWN OF ESTI- DEATH MATED											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		MONTH		YEAR			
Elizabeth Ann Beckwith						Hall		Dec		1985			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		7c. IF UNDER 1 YR.		IF UNDER 24 HRS.			
F		W		Feb 27 1981		YRS		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY		7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Ohio		USA						Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)											
Olney		Montgomery Hospital											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS		13e. STREET ADDRESS					
MD		Montgomery		Md.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1209 Mill Grove Rd.					
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME					
Charles						Beckwith		Lesta					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
N/A		N/A		216-58-5087		Samuel R. Hall-husband- (same as 13e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Elizab Beckwith</u>													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>John S. Rogers</u>		TITLE (SPECIFY) M.D. <u>John S. Rogers</u> MEDICAL EXAMINER										DATE SIGNED <u>Dec 26 1985</u>	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 1919 Seminary Rd., S.S. Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 12-27-1985		23c. NAME OF CEMETERY OR CREMATORIAL Lee's Crematory		23d. LOCATION CITY OR TOWN Washington, DC		COUNTY		STATE			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home		ADDRESS 11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR DEC 31 1985		25b. REGISTRAR'S SIGNATURE <u>Linda Williams</u>							



357053

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 3 5 1 2 4

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>JOHN C HALTON Sr.</i>						<i>12 14 85</i>				<i>12<sup>20</sup> p.m.</i>	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR	
<i>Male</i>		<i>White</i>		MONTH	DAY	YEAR	<i>44</i>			IF UNDER 2 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
<i>Pennsylvania</i>		<i>U.S.A.</i>					<i>Montg.</i>				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
<i>Takoma Park</i>		<i>Washington Adventist</i>			<i>Painter</i>			<i>Painting</i>			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		
<i>Maryland</i>		<i>P.G.Co.</i>		<i>Langley Park</i>			YES <input checked="" type="checkbox"/>		<i>3223 14TH. Ave. 20787</i>		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						
<i>Joseph</i>				<i>Halton</i>	FIRST	<i>Catherine</i>	MIDDLE	LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<i>NO</i>		<i>189-30-3901</i>		<i>Joseph Halton</i>			<i>3706 37TH. Pl. Cottage City Md.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration Pneumonia</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Airway Obstruction</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Metastatic squamous Cell Cancer of Mouth</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Severe Inanition</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>10/12/85</i> , to <i>12/14/85</i> , that (I) (we) last saw the deceased alive on <i>10/12/85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not wish the body interred.											
22b. SIGNATURE <i>Locke</i> DEGREE											
22c. ATTENDING PHYSICIAN (TYPE OR PRINT)		22d. MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>12/14/85</i>						
<i>Thomas J. Locke, Jr.</i>		<i>Second Ave Silver Spring, Md. 20910</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY	23f. STATE	
<i>Burial</i>		<i>12/18/85</i>		<i>St. Joseph Cemetery</i>			<i>Coupon</i>		<i>Cambria</i>	<i>Pa.</i>	
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
<i>W.W. Chambers Co., Inc.</i>		<i>Silver Spring, Md.</i>			<i>DEC 19 1985</i>			<i>Henderson</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 may be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned to you, it may be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 18 is marked or item 21 is marked or item 22 shows any injury, or other traumatic event, the medical certificate must be signed by the hospital or attending physician.

BP \_\_\_\_\_

DHMH - 16 60M 7-B4  
(VRA 15, 4)

BOOKS

Author	Title	Publisher	Year	Notes
John G. C. Smith	Principles of Economics	Longmans, Green & Co.	1930	1930
John G. C. Smith	Principles of Economics	Longmans, Green & Co.	1930	1930
John G. C. Smith	Principles of Economics	Longmans, Green & Co.	1930	1930
John G. C. Smith	Principles of Economics	Longmans, Green & Co.	1930	1930

006096

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be resubmitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be deposited for use on the burial permit. Then please return to hospital or attending physician.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified by the hospital or attending physician prior to burial, exhumation, or removal.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

HANDS

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST <i>Ethel</i>	MIDDLE <i>Mae</i>	LAST <i>Hands</i>	2a. DATE OF DEATH	MONTH 12	DAY 22	YEAR 85	2b. HOUR 6 10 PM		
3. SEX				4. RACE <i>white</i>			5. DATE OF BIRTH MONTH 6 - DAY 4 - YEAR YEAR 1901			6. AGE (IN YEARS LAST BIRTHDAY) YRS. 84 yrs			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Iowa</i>				7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i>			
10. CITY OR TOWN OF DEATH <i>Onley, Montgomery</i>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Brooke Grove Nursing Home</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Gaithersburg</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>809 Quince Orchard Blvd.</i>		Apt. 11 20813			
14. FATHER'S NAME FIRST <i>Nirum</i>				MIDDLE <i>J.</i>			LAST <i>Sherman</i>			15. MOTHER'S MAIDEN NAME FIRST <i>Georgiana</i>		MIDDLE LAST <i>Peck</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>543-46-9890</i>			17. INFORMANT <i>Donald D. Hands (son) Same as # 13</i>			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIO - PULMONARY ARREST TERM.</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DO TO, OR AS A CONSEQUENCE OF (b) <i>CHF.</i>												<i>Yrs.</i>	
{ DUE TO OR AS A CONSEQUENCE OF <i>ARTERIOSCLEROTIC C.V.D.</i>												<i>Yrs.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>PCP 102 CVAS (2)</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> INC. WHITE <input type="checkbox"/> BLACK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN				
21g. I certify that (I) (this hospital) attended the deceased from <i>11-19 85</i> to <i>12-22-1985</i> , that (I) (we) last saw the deceased alive on <i>12-22-85</i> , and that in my (our) opinion death occurred on the date and hour and from the cause stated above. (I) (we) did not view the body after death.									COUNTY STATE				
22a. SIGNATURE <i>D.R. Lewis MD</i>			22b. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>12/22/85</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DONALD R. LEWIS MD</i>			22e. ADDRESS <i>Onley, Md 20832</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Dec. 27, 1985</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Fir Grove Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Cottage Grove, Oregon</i>				
24. FUNERAL DIRECTOR NAME <i>Capitol Funeral Service</i>			ADDRESS <i>Falls Church, Va.</i>			25a. DATE REC'D. BY REGISTRAR <i>JAN 2 1986</i>			25b. REGISTRAR'S SIGNATURE <i>J. Anderson-Pandelle</i>				

BP

D-111 D-112 D-113 D-114 D-115 D-116 D-117 D-118 D-119 D-120

Scallop Embroidery Services Little Gullings As.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the burial permit and sent to the State Department of Health and Mental Hygiene prior to burial. If page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked as "No", item 26 shows either injury, air or other traumatic event, the medical examiner must be notified at once.

008014

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8535121

1. DECEASED NAME (TYPE OR PRINT)			FIRST Lillian MIDDLE E. LAST Harris	2a. DATE OF DEATH / MONTH DAY YEAR	2b. HOUR
3. SEX Female			4. RACE White	S. DATE OF BIRTH MONTH DAY YEAR 3 29 92	6. AGE (IN YEARS LAST BIRTHDAY) 93 IF UNDER 1 YEAR MONTHS DAYS YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		
13a. STATE MD			13b. COUNTY Montgomery	13c. CITY OR TOWN Kensington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST James MIDDLE Thomas LAST Bradburn			15. MOTHER'S MAIDEN NAME FIRST Sara MIDDLE --- LAST Robinson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. ---	17. INFORMANT William E. Harris, Myersville, Md. 21773	2555 Canada Hill Rd.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS Harris Congestive Heart Failure myocardial infarction immediate Entriacardiac Heart Disease years		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)					
DUE TO, OR AS A CONSEQUENCE OF myocardial infarction immediate Entriacardiac Heart Disease years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET	CITY OR TOWN CITY OR TOWN COUNTY STATE
22a. I certify that (I) (the hospital) attended the deceased from <u>Oct 1978</u> , that (I) (was last saw the deceased alive on <u>12/27/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Jos G. Ward</u>			22c. DEGREE MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jos G. Ward</u>			22e. ADDRESS <u>6116 Richardson, Bethesda 20817</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/31/85	23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery	23d. LOCATION CITY OR TOWN Baltimore, MD	COUNTY STATE
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016			25a. DATE REC'D. BY REGISTRAR JAN 6 1986		25b. REGISTRAR'S SIGNATURE <u>Jeanne L. Rodelle</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is checked, the death certificate may be filed within 72 hours after death.

003066

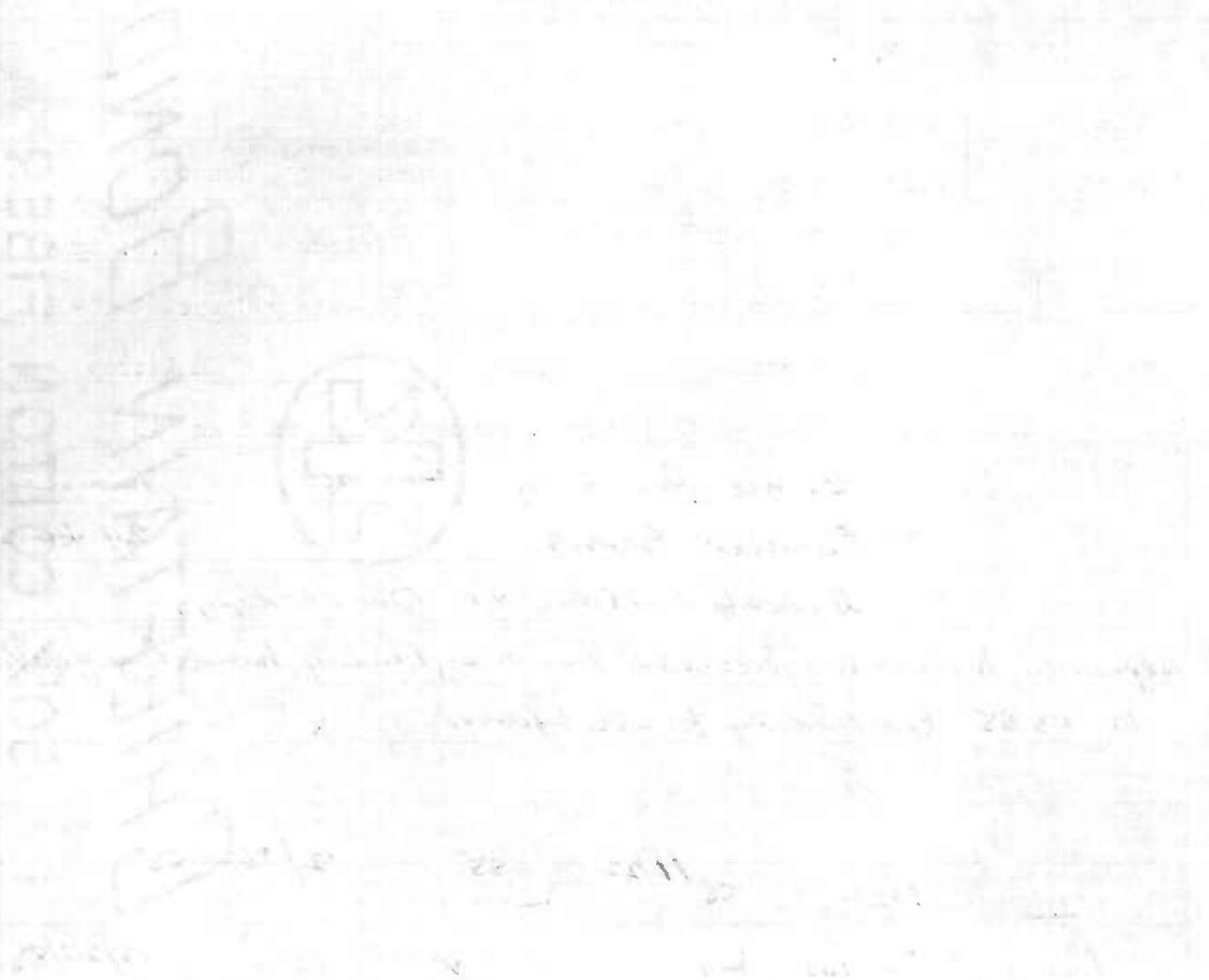
1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 5 1 2 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST <b>HARRY</b>	MIDDLE <b>P. R.</b>	LAST <b>HANSEN</b>	2a. DATE OF DEATH MONTH <b>DECEMBER</b>	DAY <b>26, 1985</b>	YEAR <b>1985</b>	2b. HOUR <b>10:07PM</b>		
3. SEX				4. RACE	5. DATE OF BIRTH MONTH <b>JUNE</b>			DAY <b>30, 1895</b>	YEAR <b>1895</b>	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS <b>90</b>	IF UNDER 24 HRS. MONTHS DAYS <b>YRS.</b>	IF UNDER 24 HRS. HOURS MIN. <b>00</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wisconsin</b>				7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County,</b> MD.				
10. CITY OR TOWN OF DEATH <b>Olney</b>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BLOC FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Officer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>		
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Silver Spring</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>14708 Bigby Court 20906</b>			
14. FATHER'S NAME FIRST <b>Robert</b>				MIDDLE <b></b>	LAST <b>Hansen</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Anna</b>			MIDDLE <b></b>	LAST <b>Reistrup</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>I, II, Korea 069-16-8597</b>			17. INFORMANT <b>Mary S. Hansen wife same as #13</b>			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				<b>Cardio Pulmonary Arrest</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.				(b) <b>Cardia Sepsis</b>						24 Hours		
				(c) <b>Hyperalimentation for Bronchoscopy.</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>Depression, malnutrition, Intestinal Trauma, Debility, initial Regurgitation</b>												
19a. DATE OF OPERATION <b>12-23-85</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Bronchoscopy, for LUL Infarate</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>11/12 1985</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET <b>18111 Prince Phillip Drive</b>			CITY OR TOWN <b>Olney, Md.</b>	COUNTY <b></b>	STATE <b></b>
22a. I certify that (I) (this hospital) attended the deceased from <b>02/26 1985</b> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated saw the deceased alive on <b>02/26 1985</b> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.												
22b. SIGNATURE <b>Oliver J. Lawless, M.D.</b>				22c. DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <b>12/27/85</b>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Oliver J. Lawless, M.D.</b>				22f. ADDRESS <b>18111 Prince Phillip Drive Olney, Md.</b>						20832		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>Dec. 27, 1985</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Metropolitan Crematory</b>			23d. LOCATION CITY OR TOWN <b>Alexandria</b>			COUNTY <b></b>	STATE <b>Virginia</b>
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 31 1985</b>			25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					
ADDRESS <b>7557 Wisconsin Ave. Bethesda, Md. 20814</b>												



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH.  
 EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1 AND 2 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 4. PAGES 3 AND 4 SHOULD BE FORWARDED TO THE FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 ARE TO BE FILED, WITHIN 72 HOURS, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 35129			
1 - STATE REGISTRAR <b>365105</b>			2a. DECEASED NAME (TYPE OR PRINT) <b>Evelyn Hargis</b>			2b. DATE KNOWN OF ESTIMATED DEATH <b>12-23 1985</b>			2b. HOUR <b>M</b>						
3. SEX <b>female</b>		4. RACE <b>caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 1, 1956</b>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS <b>29</b>		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>France</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <b>XX</b> NEVER MARRIED WIDOWED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Olney</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Staff Director</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Library</b>						
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <b>XX</b> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>24925 Dunnivant Dr, 20879</b>							
14. FATHER'S NAME FIRST <b>Harry</b>			MIDDLE <b>R.</b>			LAST <b>Hargis</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Erika</b>			LAST <b>Gessner</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>212-68-3379</b>			17. INFORMANT <b>Jesse W. Kuykendall, husband, see #13</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>8120</b> IMMEDIATE CAUSE (a) <b>Blunt Trauma to Chest</b> Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <b>XX</b> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <b>XX</b> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <b>XXXX</b> MONTH DAY YEAR <b>5:10PM 12-23 1985</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>driver in auto/auto impact</b>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <b>XX</b> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>road</b>			21f. LOCATION STREET <b>Rt. 124 near Glen Dalough Rd., Gaithersburg,</b> CITY OR TOWN COUNTY <b>Montgomery Co., Md.</b> and in my opinion									
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <b>XX</b> , Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <b>XX</b> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Dennis F. Smyth, M.D.</i>			TITLE (SPECIFY) <b>Assistant</b>			MEDICAL EXAMINER			DATE SIGNED <b>12-24-85</b>						
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>			ADDRESS <b>111 Penn St., Balto., Md. 21201</b>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>December 26, 1985</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Metropolitan Crematory</b>			23d. LOCATION CITY OR TOWN <b>Alexandria</b>			COUNTY STATE <b>Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes,</b> ADDRESS <b>P.A. 300 W. Montgomery Av., Rockville, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>DEC 27 1985</b>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>									
DHMH - 17 (VR A15 ME (5))															

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 35130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed fully, it may be used as the burial permit. Then please remove carbon paper. Pages 1 and 2 may be used within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post mortem examination will be required.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
ROBERT A. HATTER							December 6, 1985				8:30 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Male		Caucasian		October 8, 1898			87						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.		
Pennsylvania		U.S.A.					Montgomery				Government		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				
Wheaton		13013 Matey Road							Government				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		13f. ADDRESS			
Maryland		Montgomery		Wheaton		YES <input checked="" type="checkbox"/>		13013 Matey Road 20906					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
Andrew				Hatter		Leah				Lewis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes		WWI		217-44-2350		Madaline B. Hatter Wife		Same as 13					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 mins</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Atherosclerotic heart disease</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 19, 1985</u> , to <u>Dec 6, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on <u>Sept 19, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated													
22b. SIGNATURE <u>Howard S. Goldstein</u>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>12/6/85</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		<u>4701 Randolph Rd Rochelle, Md</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		CITY OR TOWN		COUNTY	STATE		
Burial		Dec. 9, 1985		Cedar Hill Cemetery		Suitland		Pr. Geo. Maryland					
24. FUNERAL DIRECTOR NAME		Francis J. Collins, Jr.		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Janet Anderson</u>					
						DEC 13 1985							

1956



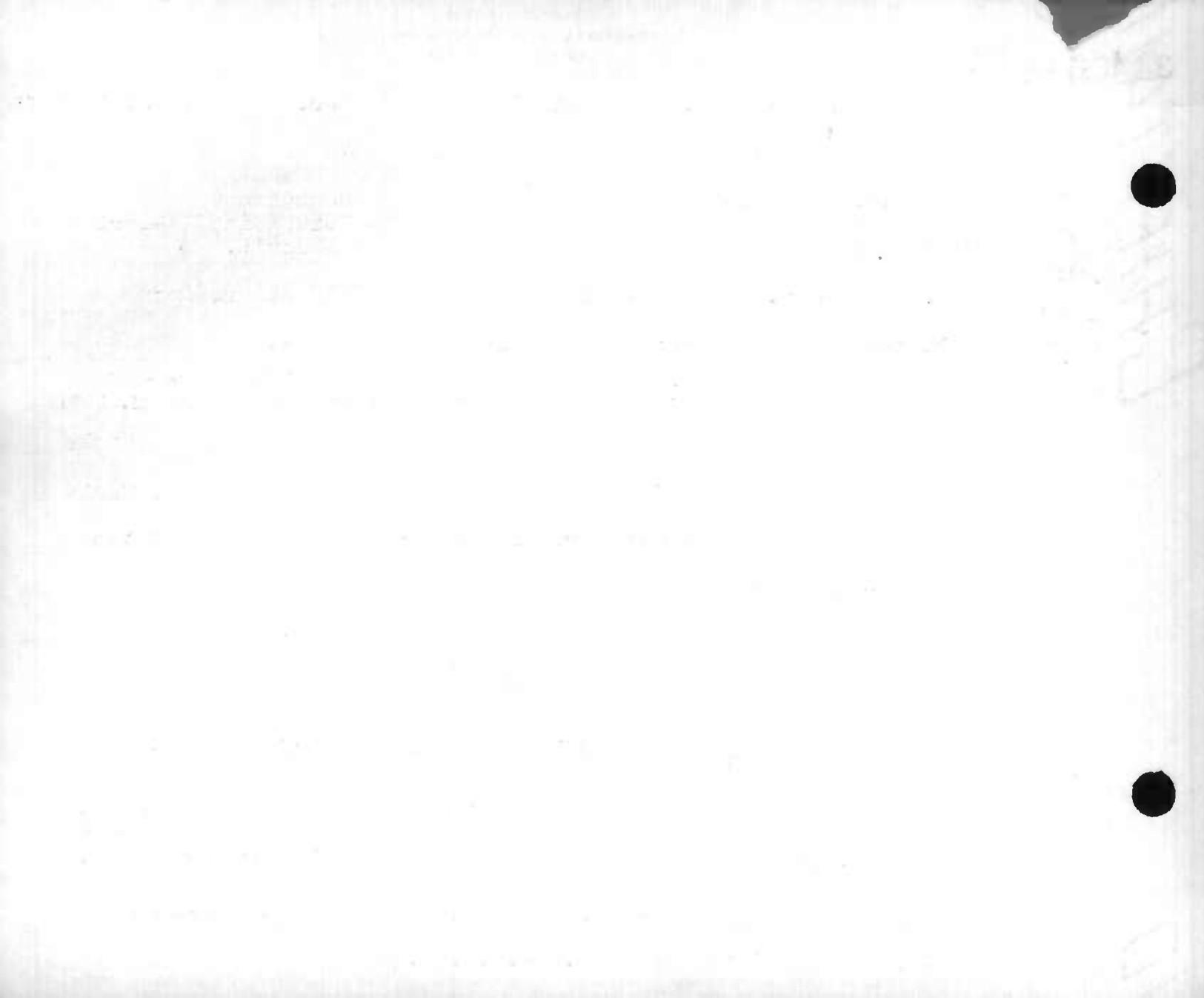
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be detached from the certificate and sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8535131					
										REG. NO.					
1 - FOR STATE REGISTRAR			1a. DECEASED NAME (TYPE OF PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			Sylvia M. Heinrichs						Dec. 4, 1985			10:18 AM			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Female			White			2 25 09			76			MONTHS DAYS		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.			
Wash, D.C.			USA						Montgomery			MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. EMPLOYER (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. PURCHASING AGENT			12c. BUSINESS OR INDUSTRY			
Brookeville			3516 Briars Road			U.S. Gov't.						Agent			
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Md.			Mont.			Brookeville						3516 Briars Road			
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			LAST			
Pierce			E			Harbin			Mae			Joy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
None			577 30 3382			Mrs. Joy H. McCary			3516 Briars Road			2 Weeks			
Brookville, Md. 20833															
18. CAUSE OF DEATH (Enter only one cause per line for item (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o))			DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pyelonephritis</u>									6 Weeks			
			DUE TO, OR AS A CONSEQUENCE OF (c) <u>Obstructive Uranoplasty</u>									2 Years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
<b>Alzheimer Disease</b>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>12/4</u> , 19 <u>85</u> , to <u>12/4</u> , 19 <u>85</u> , that (I) (we) lost saw the deceased alive above, (I) (we) did (did not) view the body after death.															
22b. SIGNATURE			DEGREE			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED						
									12/4/85						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			5225 Pooks Hill Rd. Bethesda, Md.									
John A. Galotto, MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial			Dec. 6, 1985			Arlington National			Arlington Virginia						
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Hines/Rinaldi			11800 New Hamp. Ave. S.S. Md.			DEC 6 1985			John Rinaldi						



365178

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL. ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, 1901 BOSTON TERRACE, BALTIMORE, MD. 21201. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5 35132

REG. NO.

1-  
FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>Joyce</b>	MIDDLE <b>E.</b>	LAST <b>Heitz</b>	20. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> <input type="checkbox"/> 12/18 1985	MONTH YEAR A.M. P.M.	DAY YEAR A.M. P.M.
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD <input type="checkbox"/> 12/18 1985	MONTH YEAR A.M. P.M.	
Female	White	Apr. 12, 1939				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>	MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED				
<b>Virginia</b>		<b>USA</b>						
10. CITY OR TOWN OF DEATH <b>Wheaton</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>11314 Galt Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Wheaton</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET ADDRESS <b>11314 Galt Avenue 20902</b>			
14. FATHER'S NAME FIRST <b>Gilbert</b>		MIDDLE	LAST <b>Runion</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Flossie</b>		MIDDLE	LAST <b>Shuck</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-52-9593</b>		17. INFORMANT <b>Frank Heitz</b>		ADDRESS <b>11314 Galt Ave Wheaton, Md. 20902</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic severe emphysema.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 to: <b>None</b>								
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>None</b>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER 1919 Seminary Road ADDRESS Silver Spring, Montgomery County, Md.						
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>		DATE SIGNED <b>12/18/85</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12-21-85</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Mountain Grove Cem.</b>		23d. LOCATION CITY OR TOWN <b>Fulks Run, Virginia</b>		
24. FUNERAL DIRECTOR NAME <i>Cileen Huskens</i>		ADDRESS <b>Theis Funeral Chapel, New Market, Va.</b>		25. DATE REC'D. BY REGISTRY <b>DEC 24 1985</b>		26. YEAR'S SURVEY <b>1985</b>		
DHMH 17 (VR A15 ME (5))								

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 5 1 3 3

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Bertha K.</i>	MIDDLE <i></i>	LAST <i>Hellico</i>	2a DATE OF DEATH MONTH DAY YEAR <i>Dec. 26, 85</i>	MONTH <i></i>	DAY <i></i>	YEAR <i></i>	2b HOUR 3:10 AM
3. SEX <i>Female</i>		4 RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Nov. 22, 1915</i>		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		7. IF UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D.C.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County, MD.</i>			
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Secretary (REt.)</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov't.</i>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Kensington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>3004 Findley Road (20895)</i>	
14. FATHER'S NAME FIRST <i>Simon</i>		MIDDLE <i></i>	LAST <i>Kessler</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Jennie</i>		MIDDLE <i></i>	LAST <i>Lipshitz</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>033-09-2109</i>		17. INFORMANT ADDRESS <i>Evelyn L. Getz; Daughter; 13714 Drake Drive;</i>					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>									
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> YEARS DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>CHRONIC RENAL FAILURE</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Oct 1</u> , 19 <u>80</u> , to <u>Dec 26</u> , 19 <u>85</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>Dec 25</u> , 19 <u>85</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we did) <input type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE <i>Bertha K. Shargel</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/26/85</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MARTIN C. SHARGEL</i>		22e. ADDRESS <i>3720 FARLAGUT AVE KENSINGTON MD 20895</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12/27/85</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National Cem.</i>		23d. LOCATION* CITY OR TOWN <i>Arlington, Virginia</i>			
24. FUNERAL DIRECTOR NAME <i>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</i>		ADDRESS <i>1170 Rockville Pike; Rockville, Md. 20852</i>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John T. Miller</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return certificate pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

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DHMH - 16 60M 7/B4  
(VRA 15, 4)

G. Food

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 35134

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST Bertha	MIDDLE L.	LAST Henderson	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Bertha L. Henderson</i>				12/26/85				10:00 PM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Female		Cauc.		MONTH	DAY	YEAR	85	IF UNDER 1 MONTH	IF UNDER 1 DAY	IF UNDER 4 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.		
Miss.		USA					Montgomery			MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Rockville		Potomac Valley Nursing Home		Homemaker			Own Home					
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Md		Montgomery		Kensington			3724 Nimitz Rd./20895					
14. FATHER'S NAME		FIRST Mike	MIDDLE R.	LAST Fulgham	FIRST Pearl	MIDDLE McCoy	LAST Azwell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS					
No		220-48-0676		Christopher L. Henderson, Same as #13.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) <i>Cardsopatory Arrest</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic cerebrovascular disease</i>							YEARS			
		DUE TO, OR AS A CONSEQUENCE OF (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Senile dementia, Recent urinary tract infection</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (1) <input type="checkbox"/> (his/her) attended the deceased from <i>October 19, 83</i> to <i>Dec 26, 1985</i> , that (2) <input type="checkbox"/> (we) last saw the deceased alive on <i>Dec 26, 1985</i> , and that in (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. If (we) did not view the body after death.												
22b. SIGNATURE		22c. DEGREE		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED					
<i>Ruth Rosenberg</i>		MD					12-26-85					
22f. PHYSICIAN'S NAME (TYPE OR PRINT)		22g. ADDRESS		22h. ADDRESS			22i. ADDRESS					
<i>Ruth Rosenberg, MD</i>		10313 GEORGIA AVE, SILVER SPRING, MD					20902					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY		
Burial		12/30/85		Parklawn Memorial Pk.			Rockville, MD			STATE		
24. FUNERAL DIRECTOR NAME		Joseph Gawler's Sons, Inc.		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
				ADDRESS								
5130 Wisconsin Ave, NW, Washington, D.C.		20016		JAN 6 1986			<i>John L. Johnson, Jr.</i>					

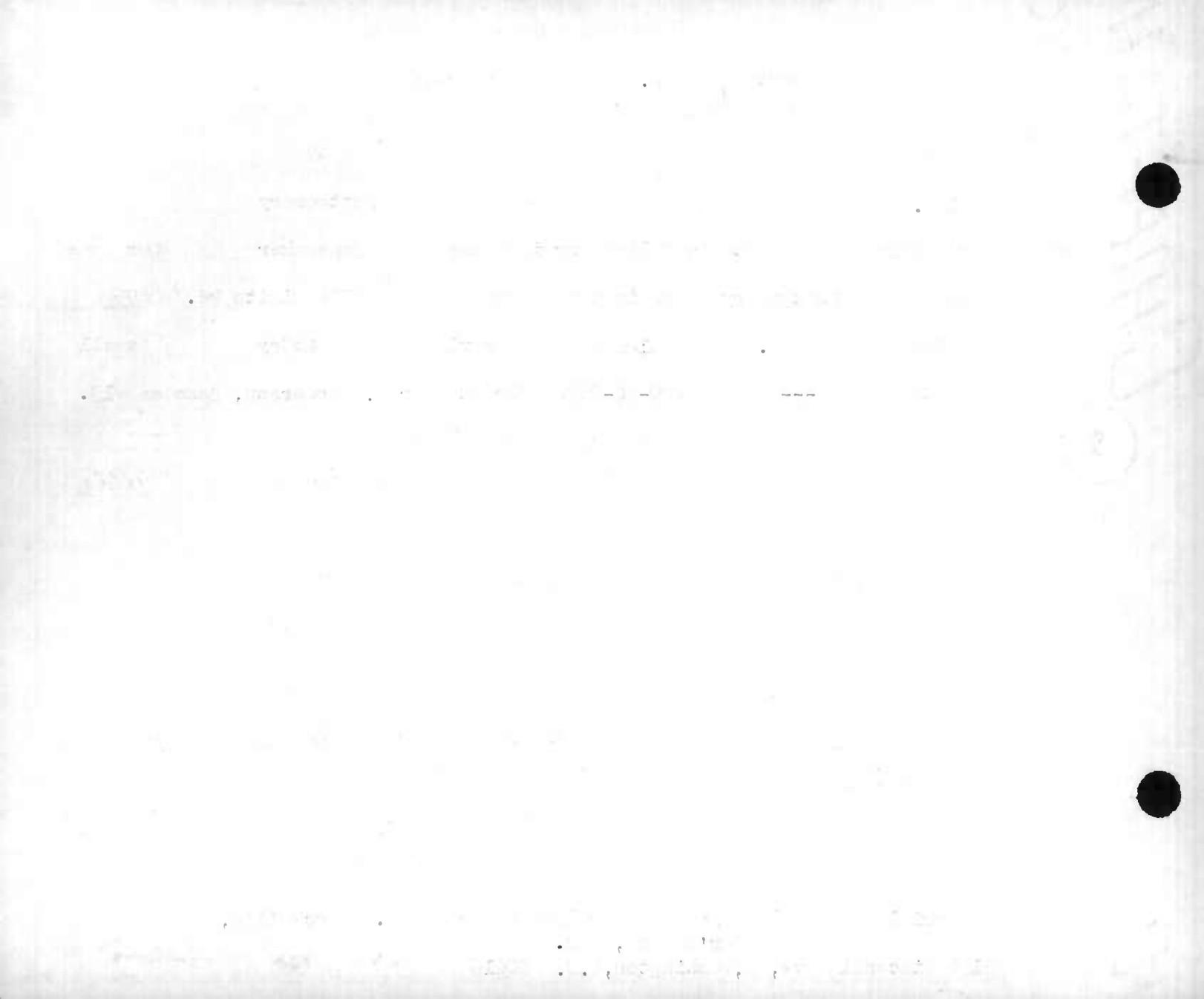
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove Part I and II and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If Item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 2 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

350094

85 35135

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<b>BESSIE CUSTER HENRY</b>						<b>12/6/85</b>				<b>10 A.M.</b>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
<b>Female</b>		<b>white</b>		MONTH <b>DECEMBER</b> DAY <b>29</b> YEAR <b>1898</b>		86		YEARS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MONTGOMERY			
<b>MARYLAND</b>		<b>USA</b>									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
<b>GAITHERSBURG</b>		<b>WILSON HEALTH CARE CENTER</b>				<b>RETIRED CURTAIN SHOP OPERATOR</b>					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		21502	
<b>MARYLAND</b>		<b>ALLEGANY</b>		<b>CUMBERLAND</b>				<b>160 BEDFORD STREET</b>			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST	ADDRESS	
		<b>HARRY</b>	<b>C.</b>	<b>OGLEBAY</b>			<b>ALICE</b>	<b>ELIZABETH</b>	<b>BALOUS</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.				17. INFORMANT		GAITHERSBURG MARYLAND			
<b>NO</b>		<b>220-40-1006</b>				<b>ELSIE PABST % WILSON HEALTH CARE CENTER</b>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
<b>6 months</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINUMA - Lung, brain</b>											
DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA - BREAST</b>											
DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>											
19. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>12/5/85</b> , 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did not view the body after death.											
22b. SIGNATURE <b>Thos G. Ward, M.D.</b> DEGREE <b>MD</b>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <b>Thos G. WARD, 6116 Robinwood, Bethesda 20817</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <b>DEC 9 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST CEMETERY</b>		23d. LOCATION CITY OR TOWN		CUMBERLAND ALLEGANY		MARYLAND	
24. FUNERAL DIRECTOR NAME <b>SILCOX-MERRITT FUNERAL HOME CUMBERLAND, MARYLAND</b>		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE <b>DEC 11 1985 Julianne P. [Signature]</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used.

005030

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 80 351 30

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
JOSE ANTONIO HERNANDEZ						DECEMBER 21, 1985				4:20 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
MALE		CAUCASIAN		MONTH NOVEMBER DAY 6, 1921 YEAR		64		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
CUBA		CUBA				MONTGOMERY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
SILVER SPRING		8720 COLESVILLE ROAD # 106		CASHIER		BANKING					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8720 COLESVILLE ROAD #106 20910			
14. FATHER'S NAME FIRST QUINTIN		MIDDLE ALBERTO		LAST HERNANDEZ		15. MOTHER'S MAIDEN NAME FIRST CATALINA		MIDDLE		LAST HERNANDEZ	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-94-9307		17. INFORMANT MARIA HERNANDEZ WIFE		ADDRESS SAME AS 13					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic carcinoma of stomach</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 2, 1985</i> , to <i>Dec 21, 1985</i> , that (I) (we) last saw the deceased alive on <i>Dec 19, 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Jorge H. Forcada</i>		DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/21/85</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jorge H. Forcada</i>		22e. ADDRESS <i>1100 Spring St. S. S. 3rd 20910</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/23/85		23c. NAME OF CEMETERY OR CREMATORIAL GATE OF HEAVEN		23d. LOCATION CITY OR TOWN SILVER SPRING MONTGOMERY MD.		23e. COUNTY STATE			
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS JR.</i> ADDRESS 500 UNIVERSITY BLVD., W. SILVER SPRING, MD.		25a. DATE REC'D. BY REGISTRAR JAN 02 1986		25b. REGISTRAR'S SIGNATURE <i>Jean Davidson-Kindell</i>							

BP \_\_\_\_\_



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3535137

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
		Elizabeth R.		Hess	12	29	85		4:10 a.m.
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR (MONTHS DAYS)	
FEMALE		WHITE		MAR. 10 1900		85		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
maryland		USA				MONTGOMERY CO.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
ROCKVILLE		NATIONAL LUTHERAN HOME		HOMEMAKER		AT HOME			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
MARYLAND		BALTIMORE RANDALLSTOWN				YES <input checked="" type="checkbox"/>		3717-COURTHOUSE DR. 21133	
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST		
charles		-	Rudolph	Regina		--	Maurer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO		215-01-0254		REV. DR. RICHARD REICHARD-NLH-ROCKVILLE					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b, and 1c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanotic Adenocarcinoma of Colon</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 years</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 3-27, 19 85, to 12-29, 19 85, that (I) (we) last saw the deceased alive on 12-29-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) remove the body after death.									
22b. SIGNATURE <u>Thomas E. Dooley, M.D.</u>		DEGREE							
22c. DATE SIGNED <u>12/29/85</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Thomas E. Dooley, M.D.</u>		ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>							
22e. ADDRESS <u>17904 Georgia Avenue Derby, Maryland 20832</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN. 2/86		23c. NAME OF CEMETERY OR CREMATORIAL MEADOWRIDGE MEM. PK.		23d. LOCATION ELKRIDGE, MARYLAND STATE			
24. FUNERAL DIRECTOR NAME HYSONG CO., INC-1300 N ST., NW		ADDRESS WASH., DC		25a. DATE REC'D. BY REGISTRAR JAN 8 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Pendle</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

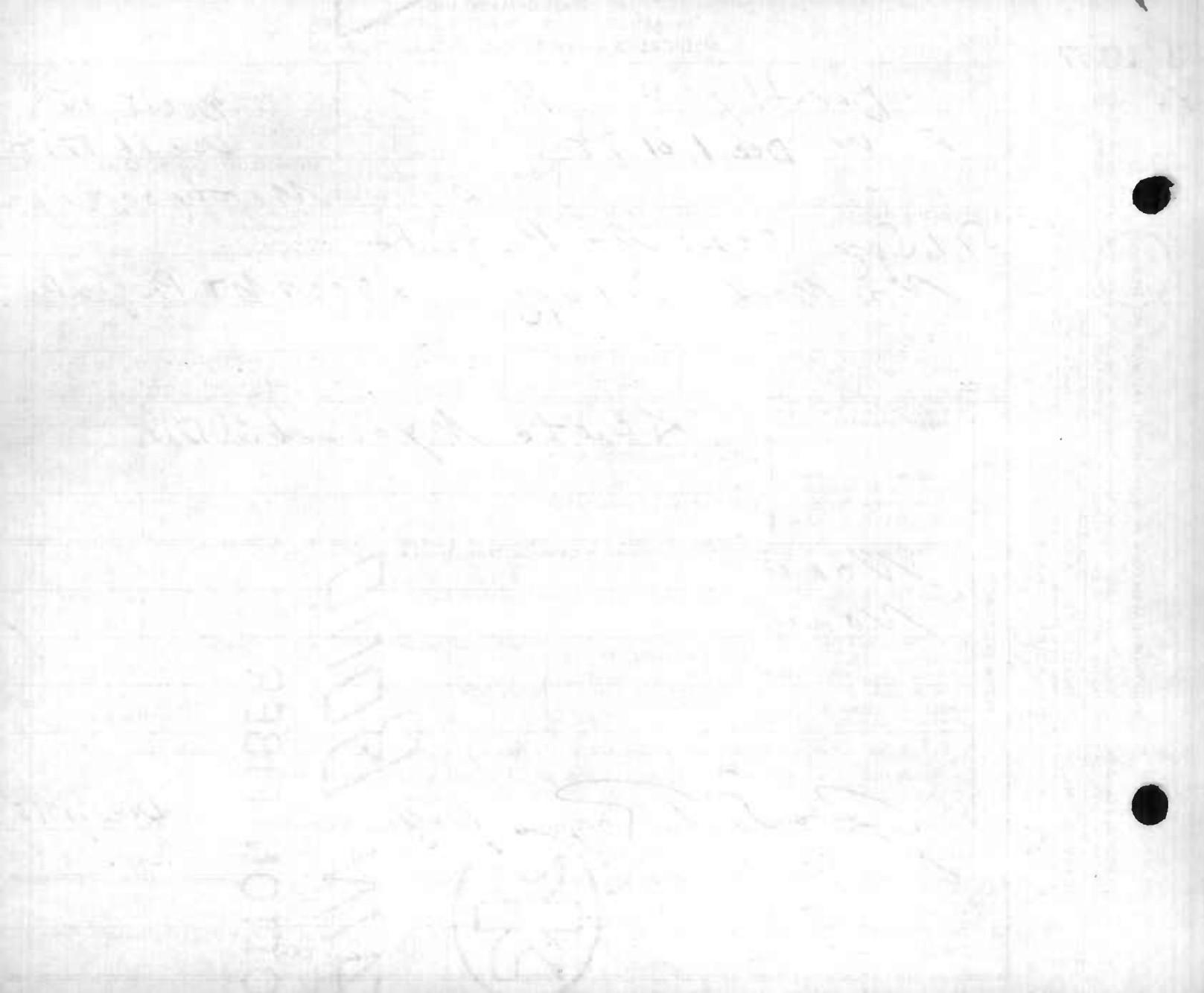
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, file medical certificate.

2001 Final

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3 5 1 3 5													
1- STATE REGISTRAR			FIRST			MIDDLE			LAST			2a DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR			2b. HOUR										
1. DECEASED NAME (TYPE OR PRINT)			<i>Dorothy H. Heuer</i>									Dec 15 1985			PM										
3. SEX			F			W			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			7. IF UNDER 1 YR. MONTHS DAYS			8. IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			UNKNOWN			Dec 1, 1984			USA			8. CITIZEN OF WHAT COUNTRY?			9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD.</i>							
10. CITY OR TOWN OF DEATH			Si Spn			Md. Monk.			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			9221 Mt. Pisgah Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE			3b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 9221 Mt. Pisgah Rd.			2016										
14. FATHER'S NAME			FIRST Walter			MIDDLE B			LAST Hoofnagle			15. MOTHER'S MAIDEN NAME UNKNOWN													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			16c. INFORMANT			16d. ADDRESS																
None			578-28-6800			Wilson W. Heuer (Step son)			631 Santa Paula St. Tucson, Ariz.			85706													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cute Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																									
(c) _____																									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																									
None			19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE										
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															and in my opinion										
<i>Roger Rogers, M.D.</i>															TITLE (SPECIFY) MEDICAL EXAMINER										
EXAMINER'S NAME (TYPE OR PRINT)			John S. Rogers MD			ADDRESS			1919 Seminary Rd. S.S. Md.			DATE SIGNED <i>Dec 17 1985</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 12/20/85			23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN Suitland			COUNTY			STATE										
24. FUNERAL DIRECTOR Himes/Rinaldi			11800 New Hamp. Ave. Silver Spring, Md.						25a. DATE REC'D. BY REGISTRAR DEC 23 1985			PG			Md.										



352092

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

85 35139

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be used as the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner

X DECEASED NAME FIRST MIDDLE LAST				2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Elinor M. Hickerson</i>				December 11, 1985				11:00P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		Caucasian		April 30, 1910		75		MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		United States				Montgomery County, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Chevy Chase		4716 Bradley Blvd #104		Office Manager		Insurance			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland		Montgomery		Chevy Chase		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4716 Bradley Blvd. #104 20815	
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME					
Robert		Lee Hickerson		Mary					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Mrs. Marilyn E. Judge, Executrix, ADDRESS 10116 Tenbrook Drive, Silver Spring, MD. 20901		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		577-07-9841				4 months			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatocellular Carcinoma</i>									
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								(b)	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Laennec's Cirrhosis</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) ( <i>XXXXXX</i> ) attended the deceased from 17 Nov 1975 to 11 Dec 1985, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 19 Nov 1985, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) ( <i>XXXXXX</i> ) (did not) view the body after death.									
22b. SIGNATURE <i>David G. Luthringer</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED December 12, 1985			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>David G. Luthringer, M.D.</i>		22e. ADDRESS 5530 Wisconsin Ave. Chevy Chase, Maryland 20815							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE Dec. 14, 1985		23c. NAME OF CEMETERY OR CREMATORIUM St. Rose of Lima Cemetery		23d. LOCATION Gaithersburg, Maryland		CITY OR TOWN COUNTY STATE	
24 FUNERAL DIRECTOR NAME <i>Robert A. Pumphrey</i> ADDRESS <i>Funeral Homes, P.A.</i> 7557 Wisconsin Ave., Bethesda, Maryland 20814				25a. DATE REC'D. BY REGISTRAR DEC 16 1985		25b. REGISTRAR'S SIGNATURE <i>Jane Anderson-Wendell</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the hospital or attending physician.

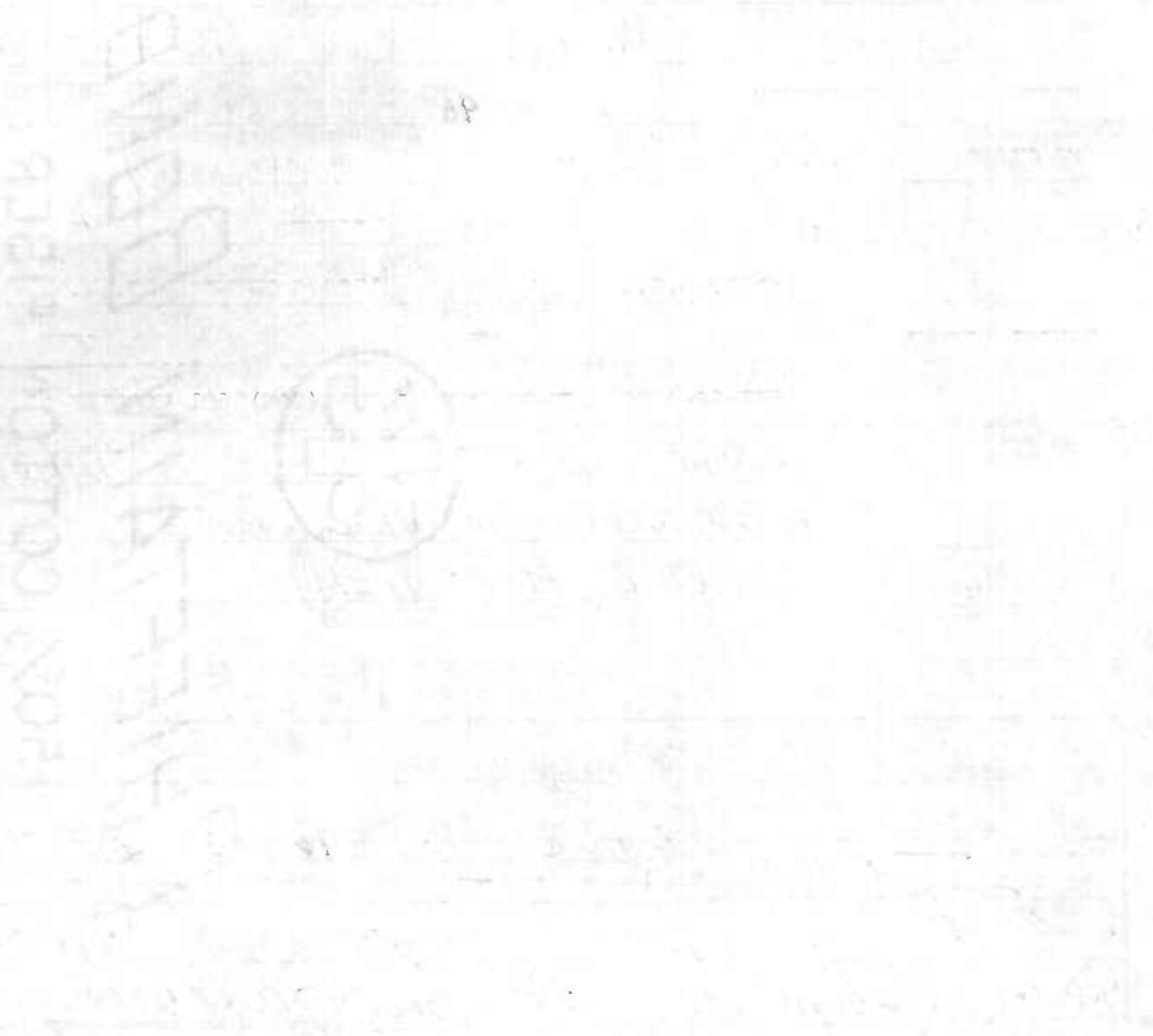
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 3 and 4 should be detached for use as the Burial/Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT): If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 853203	85 35140
1. FOR STATE REGISTRAR	FIRST LAST	MIDDLE	20. DATE OF DEATH MONTH DAY YEAR	2b HOUR	
1. DECEASED NAME (TYPE OR PRINT)	William	Higman	12-9-85	7:20 P.M.	
3. SEX MALE	4 RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 2 - 10 - 96	6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE COUNTRY MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery	MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN A HOSPITAL, GIVE STREET ADDRESS) Holy Cross Hospital	12a. USUAL OCCUPATION LAWYER	12b. KIND OF BUSINESS OR INDUSTRY N/A		
13a. STATE MD	13b. COUNTY WASH., D.C.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1709 CRESTWOOD DR., N.W. 99999		
14. FATHER'S NAME FIRST MIDDLE LAST DANIEL HIGGMAN	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANN ROWSE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 577-60-4589	17. INFORMANT JOHNATHAN HIGGMAN (SON) 2601 WOODLEY PL., N.W.,	ADDRESS #115, WASH., D.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC VASCULAR Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF (c) DISEASE AND UREMIA					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (we) attended the deceased from 6 DEC 1985 to 9 DEC 1985, that (I) (we) last saw the deceased alive on 9 DEC 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE WALTER E. GOODRICH MD					
22c. DEGREE ATTENDING MEDICAL DIRECTOR STAFF PHYSICIAN <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/>					
22d. DATE SIGNED 10 DEC 85					
22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD 20902					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 12-10-85	23c. NAME OF CEMETERY OR CREMATORIUM LEE CREMATORIUM	23d. LOCATION WASHINGTON, D.C.		
24. FUNERAL DIRECTOR VANN & WILLIAMS, 4804 GA. AVE., N.W., WASH., D.C.	25a. DATE REC'D. BY REGISTRAR DEC 17 1985	25b. REGISTRAR'S SIGNATURE John Williams			
DHMH - 16 60M 7/84 (VRA 15, 4)					

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 5 1 4

REG. NO.

1 -  
FOR  
STATE  
REGISTRAR

I. DECEASED NAME      FIRST      MIDDLE      LAST				2a. DATE OF DEATH      MONTH      DAY      YEAR	2b. HOUR				
<i>Margaret C. Hines</i>				December 29, 1985		2:10AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH      DAY      YEAR		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS      DAYS			
Female		Caucasian		January 4, 1901		84      YRS			
7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Carriage Hill of Silver Spring		Housewife		Own Home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				Washington, DC		13e. STREET ADDRESS / ZIP CODE 2334 39th Street, N.W. 20007			
14. FATHER'S NAME FIRST      MIDDLE      LAST		15. MOTHER'S MAIDEN NAME FIRST      MIDDLE      LAST							
Theodore		Nellie		Burke					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		1900 Eads Street Arlington, Virginia 22202			
No		578-64-6340		Son Walter A. Hines					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)      Respiratory failure      APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.      5 days									
DUE TO, OR AS A CONSEQUENCE OF      Pneumonia      6 days									
(b)      DUE TO, OR AS A CONSEQUENCE OF									
(c)      DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Parkinson's disease , Rt. hemi plegia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M.      MONTH      DAY      YEAR P.M.      19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN      COUNTY      STATE			
22a. I certify that (I) (this hospital) attended the deceased from Oct. 11, 1985, to Dec. 29, 1985, that (I) (we) last saw the deceased alive on Dec. 27, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Robert V. Choisser</i>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED Dec. 29, 1985			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 5530 Wisc. Ave., Chevy Chase, Md. 20815							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 3, 1986		23c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN      COUNTY      STATE Silver Spring      Maryland			
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOMES, PA. 7557 Wisconsin Ave., Bethesda, Maryland 20814		25a. DATE REC'D. BY REGISTRAR JAN 3 1986		25b. REGISTRAR'S SIGNATURE <i>Lila Kline</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed and witnessed by a physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Please send a copy of this certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

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DHMH - 16 60M 7/B4  
(VRA 15, 4)



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the attending physician, page 3.

rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and nothing should be written for use as the burial/cremation permit. Then please remove carbon copies. Pages 2 and 3 should be retained by the State Dept. of Health and Mental Hygiene prior to burial/cremation; do not remove.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85	35	142	
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Frederick Hinrichs			Frederick		Hinrichs	12/12/85					85	89 M	
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male			White	Month Day Year June 18, 1899			86			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
WI			U.S.A.						Montgomery MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Beth			Suburban Hospital			Manufacturer			Steel Co.				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13e. STREET ADDRESS / ZIP CODE			
13a. STATE	MD	13b. COUNTY	Mont.	13c. CITY OR TOWN	Bethesda	13d. INSIDE CITY LIMITS?	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	5301 Westbard Circle 20816				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST				
			William		Hinrich	Clara			Weigell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS				
Yes			WW I-WW II			38807-1796			St. Louis				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Shock										8 hours			
DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis										8 hours			
DUE TO, OR AS A CONSEQUENCE OF (c) Widespread Prostatic Carcinoma years													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
Organic Brain Syndrome			Congestive heart Failure										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (this hospital) attended the deceased from 11/1/85 to 12/12/85, that (we) lost saw the deceased live an 12/12/85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, check here.)										22c. DATE SIGNED 12/12/85			
22b. SIGNATURE Robert H Blee										DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS										
Robert H Blee MD			8218 Wisconsin Ave Bethesda										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE
Cremation			12/16/85			Mt. Comfort Cem.			Alex., VA				
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE DEC 19 1985	

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synthesis

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lead

concentration

functional compounds

after heating 1 hr

x

synthesis

no

heating

brief

detected

no

no heating no heat synthesis

synthesis

no



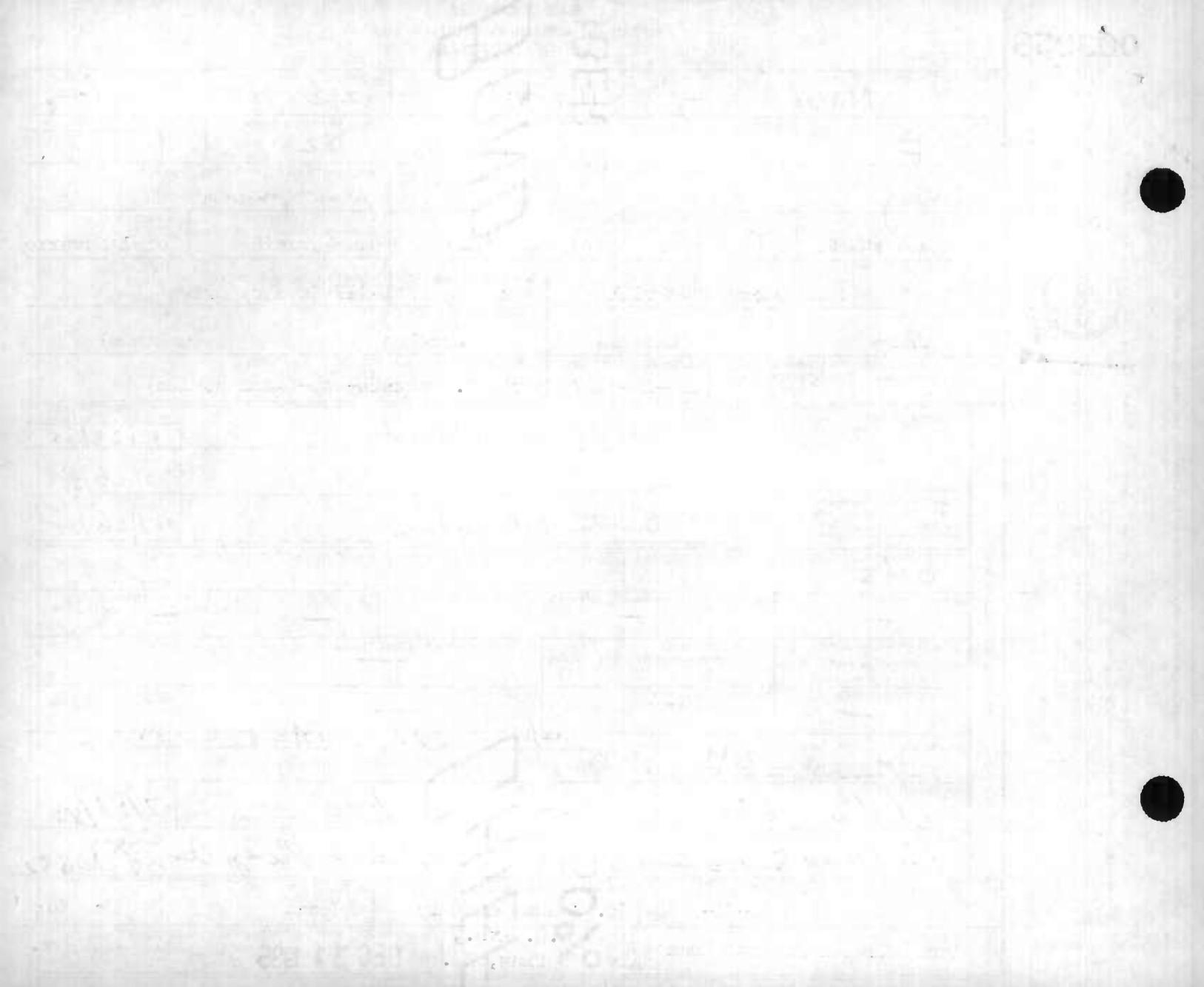
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and some copy filed in the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon aback. Pages 1 and 2 will be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or Item 18 shows any injury or other traumatic event, the medical certification section must be completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 3 5 1 4 6					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
MARIE		-				Hotakh		12/28/85					1:40 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH			
F		W		MONTH 9 DAY 21 YEAR 03		82 YRS.		Germany		US		Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Friends Nursing Home										Chambermaid		Hotel Navarro	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE							
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16517 Cavalry Drive							
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME							
		Jacob				Basslee		Dorothea				(unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. ADDRESS		17. INFORMANT									
N/A		N/A		110-12-5197		Marie P. Fertsch-dau-(same as 13e)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												12/28/85			
DUE TO, OR AS A CONSEQUENCE OF (b) _____												12/26/85			
DUE TO, OR AS A CONSEQUENCE OF (c) _____												12/26/85			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
OMS		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
		-		-		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR AM MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____											
22a. I certify that (I) (this hospital) attended the deceased from 12/16/85 to 12/28/85, that (I) (we) last saw the deceased alive on 12/24/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.															
22b. SIGNATURE <i>Arthur Shugelman</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/28/85									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Arthur Shugelman</i>		22e. ADDRESS 18111 Prairie Ridge Dr no 20832													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-31-1985		23c. NAME OF CEMETERY OR CREMATORIAL St. Johns Cemetery		23d. LOCATION CITY OR TOWN Queens		COUNTY		New York					
24 FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		ADDRESS 11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR DEC 31 1985		25b. REGISTRAR'S SIGNATURE <i>Jane Deardon Rinaldi</i>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death is reported by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 3 5 1 4 4			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
<i>MARGARET</i>			<i>P.</i>	<i>HOUGH</i>		<i>December 31, 1985</i>						<i>4:30 p.m.</i>	
3. SEX			4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
<i>FEMALE</i>			<i>CAUCASIAN</i>	<i>JUNE 15 1902</i>			<i>83</i>			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
<i>WASHINGTON, D.C.</i>			<i>U.S.A.</i>						<i>Montgomery County</i>				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
<i>Olney</i>			<i>Montgomery General Hospital</i>			<i>Secretary</i>			<i>LIFE INS. CO.</i>				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS	
<i>MARYLAND</i>			<i>MONTGOMERY</i>			<i>SILVER SPRING</i>			YES <input type="checkbox"/> NO <input type="checkbox"/>			<i>15414 BRAMBLEWOOD DRIVE 20906</i>	
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	ADDRESS			
<i>EDWARD</i>				<i>PITCHER</i>	<i>LOLA</i>			<i>MAE</i>	<i>FAUX</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<i>NO</i>			<i>258-54-6176</i>			<i>COL. JOHN F. HOUGH HUSBAND SAME AS 13</i>			<i>minutes</i>				
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b) and (c). PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <i>cardiac respiratory arrest</i>													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>septicemia</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Repetited aspiration pneumonia</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>old CVA</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>October 8, 1985</i> to <i>12/31, 1985</i> , that (I) (we) last saw the deceased alive on <i>12/31, 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <i>Marian Chung</i>			22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>12/31/85</i>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MARIAN CHUNG MD</i>			22f. ADDRESS <i>3701 Rossman Blvd Silver Spring Md.</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>JAN. 6, 1986</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>ARLINGTON NATIONAL</i>			23d. LOCATION CITY OR TOWN <i>ARLINGTON</i>			COUNTY	STATE
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS JR.</i>			ADDRESS <i>500 UNIVERSITY BLVD. W. SILVER SPRING, MD.</i>			25a. DATE REC'D. BY REGISTRAR <i>JAN 6 1986</i>			25b. REGISTRAR'S SIGNATURE <i>Jean Davidson Pendleton</i>				

may be

, page 3  
the future  
of her death

, and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

The medical examiner must be notified at once.

If item 21 is marked or if item 18 shows any injury, or other traumatic event,

the medical examiner must be notified at once.

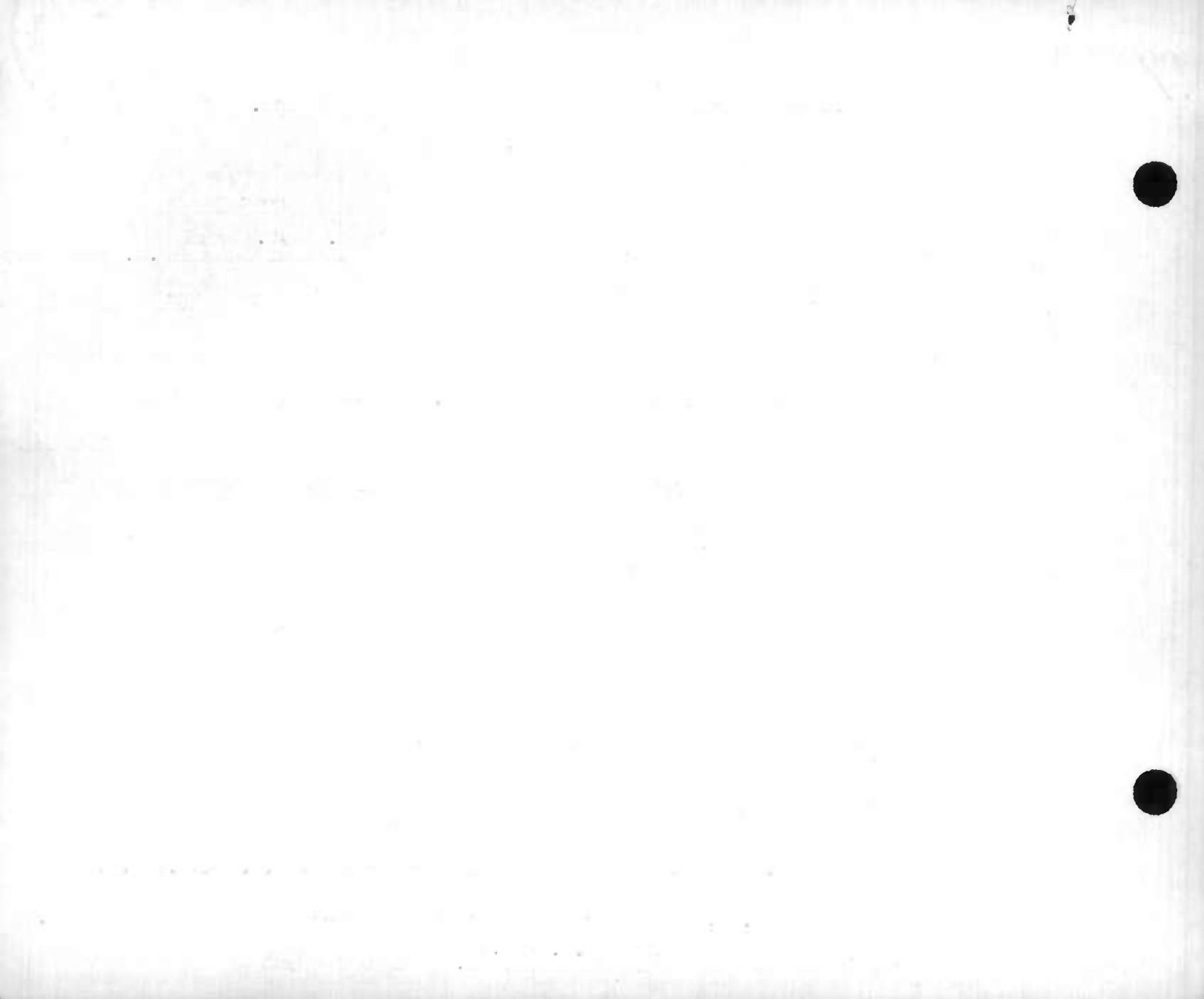


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or coroner should be notified of the same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8535145				
										REG. NO.				
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR				
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST		Dec. 30 1985			100 AM			
Thomas Tin Fah Huang														
3. SEX Male			4. RACE Oriental			5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 66			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Jan 15 1919						7. BIRTHPLACE COUNTRY China		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a. USUAL OCCUPATION Dept. Asst. Legal Advisor			12b. KIND OF BUSINESS OR INDUSTRY U.S. State Dep					
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Rockville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE #6 Old Gate Court 20852		
14. FATHER'S NAME FIRST Lunking			MIDDLE Wong			15. MOTHER'S MAIDEN NAME FIRST Loochie			MIDDLE LAST Moi					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A			16b. SOCIAL SECURITY NO. N/A			17. INFORMANT Louray T. Huang-wife-(same as 13e)			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for 10a, (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18c. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular disease, CAD</u>			18d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediately</u>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			18e. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>			18f. 5 years						10 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Diabetes mellitus</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from <u>6/5 1985</u> to <u>12/30 1985</u> , that (2) (we) lost saw the deceased alive on <u>11/11 1985</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (3) (we) did not view the body after death.														
23. SIGNATURE <u>Jm. Collier Harvey MD</u>			24. PHYSICIAN'S NAME (TYPE OR PRINT) John C. Harvey, MD			25. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			26. DATE SIGNED <u>12/30/85</u>					
23b. ADDRESS 3800 Reservoir Road, N.W. Wash., D.C.														
23c. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23d. DATE Jan. 2, 1986			23e. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery			23f. LOCATION CITY OR TOWN Rockville			COUNTY STATE Montgomery Md.		
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home			25. DATE REC'D. BY REGISTRAR DEC 31 1985			26. REGISTRAR'S SIGNATURE <u>Jane Lander-Hanley</u>								



347085

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM BM-5 RETAIN COPIES FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 3 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 5 3 5 1 4 0						
1- STATE REGISTRAR																		
I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI. DEATH MATED			2b. HOUR			
CORLISS L. HUDSON												<input checked="" type="checkbox"/> 12-2-85 T9			2d HOUR			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			2d HOUR	
Female		Black		June 2, 1962			23 yrs.							12-2-85 T9			4:48PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH											
Georgia		USA		<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Montgomery County											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Silver Springs		Holy Cross Hospital			Collator			Ctr. for Hdcp										
13a. STATE MD		13b. COUNTY Montg.		13c. CITY OR TOWN Wheaton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4119 Conger Street/ 20906									
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME LAST														
Charles A. Hudson, Jr.				Evelyn Dixon														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		17. INFORMANT Charles Hudson, Jr. (Father) same as #13			ADDRESS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>chromosomal abnormality</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) <i>Margarita A. Korell</i>						
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.												M.D. Assistant			MEDICAL EXAMINER			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 12-6-85			23c. NAME OF CEMETERY OR CREMATORIAL Hutchings Funeral Home			23d. LOCATION CITY OR TOWN Macon,			COUNTY Georgia			STATE				
24. FUNERAL DIRECTOR NAME George R. Snowden		ADDRESS 246 N. Washington St. Rockville, MD 20850			25a. DATE REC'D. BY REGISTRAR REC'D. 12-6-85			25b. REGISTRAR'S SIGNATURE <i>Julie Johnson-Parker</i>										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remember to file a copy with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other significant condition, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85	35	41					
										REG. NO.							
1 - STATE REGISTRAR			1. DECEASED NAME			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
			Margaret Moran					Hudson	Dec. 25, 1985						10:25A M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 MRS			
Female			White			Jan. 20 1899			86			YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Washington, D.C.			U.S.A.						Montgomery County								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Bethesda			CARRIAGE HILL - BETHESDA			Homemaker			Home								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE			
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			5215 Cedar Lane 20814								
Maryland			Mont.			Bethesda											
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME								
Thomas			Pa trick			Moran			Anna								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			LAST					
No			578-62-3421			J.E. Murdock, 111. 5206 Wehawken Rd., Beth.			Maryland			O'Donnell					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u>							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Stroke</u>										<u>1 month</u>							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.(a) <u>ischaemic heart disease</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>December 19, 1985</u> to <u>December 25, 1985</u> , that (I) (we) last saw the deceased alive on <u>Dec. 24 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED <u>12/25/85</u>							
22b. SIGNATURE <u>Thomas C. Ha vell, M.D.</u>										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
Thomas C. Ha vell, M.D.			4201 Cathedral Ave., N.W. D.C. 20016														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY		STATE			
Burial			12/30/1985			Arlington National Cem.			Arlington			Virginia					
24. FUNERAL DIRECTOR NAME 5130 Wisc. Ave., N.W. Wash., D.C.			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
						DEC 31 1985											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

002142

Film G611 item 5

1 - FOR  
STATE  
REGISTRAR

1/8/86

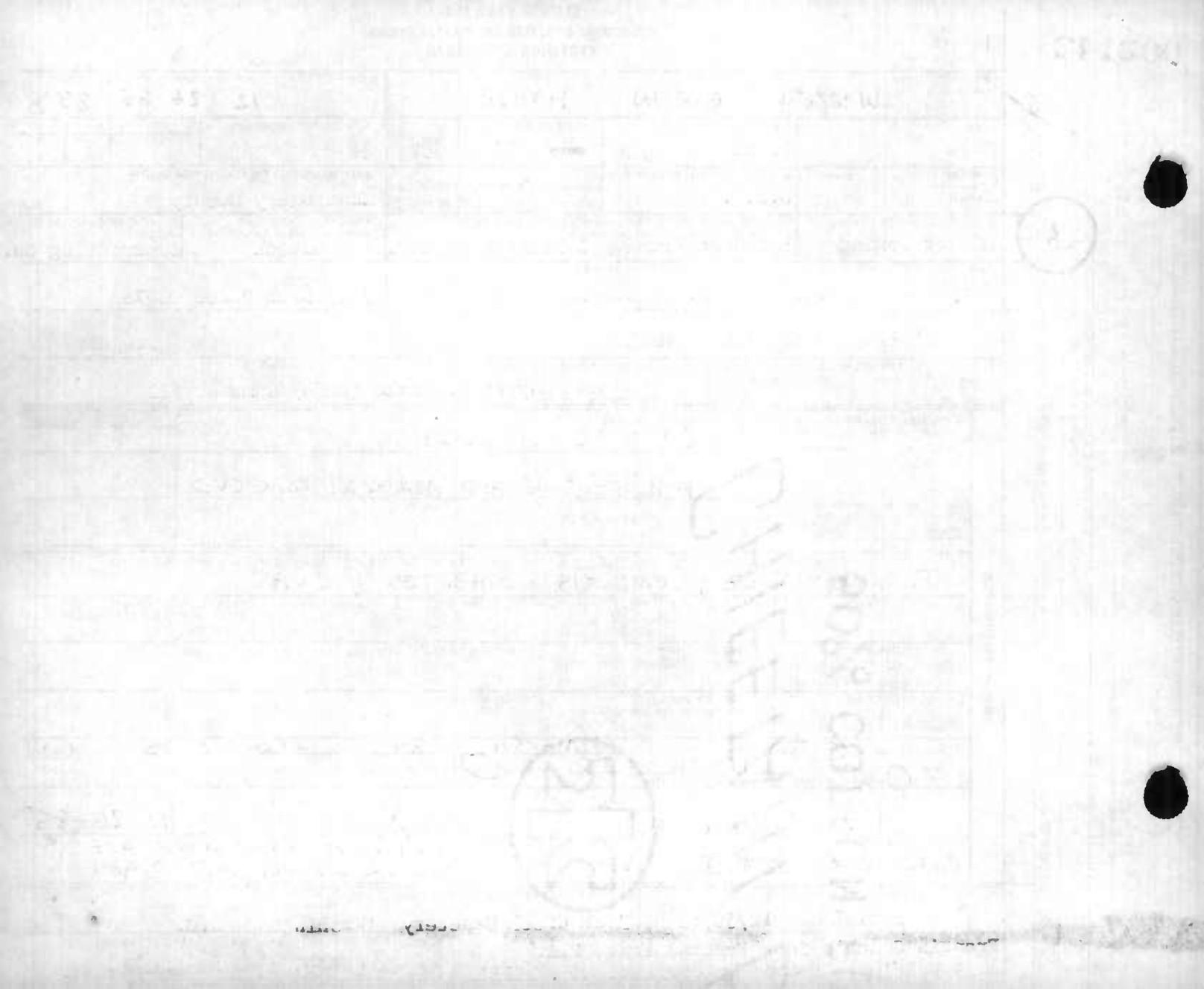
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 3 5 1 4 5

1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>WARREN</b>	MIDDLE <b>GLENN</b>	LAST <b>HUMKE</b>	2a. DATE OF DEATH	MONTH <b>12</b>	DAY <b>26</b>	YEAR <b>85</b>	2b. HOUR <b>830 PM</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>07</b> DAY <b>11</b> YEAR <b>1897</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b>	IF UNDER 1 YEAR MONTHS <b>YRS.</b>	IF UNDER 24 HRS MONTHS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b>	IF UNDER 24 HRS MIN. <b>0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Iowa</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>						
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fairland Nursing &amp; Retirement Ctr.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Accountant</b>							
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>W. Hyattsville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>5029 37th Place 20782</b>					
14. FATHER'S NAME FIRST <b>William</b>		MIDDLE <b>Frederick</b>	LAST <b>Humke</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Margaret</b>					MIDDLE <b></b>	LAST <b>Steiner</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO <input type="checkbox"/>		16b. SOCIAL SECURITY NO. <b>577-09-8716</b>		17. INFORMANT <b>Myrna P. Humke (Wife) Same as #13</b>					ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE AND ATHEROSCLEROTIC CVD</b>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <b>PARKINSON'S DE ; DEMENTIA ; DIABETES ; CVA</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (1) <b>this hospital</b> attended the deceased from <b>MARCH 19 84</b> to <b>DECEMBER 19 85</b> , that (1) <b>we</b> last saw the deceased alive on <b>12-26-1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) <b>we</b> (did) did not view the body after death.										22c. DATE SIGNED <b>12-26-85</b>	
22b. SIGNATURE <b>Charles M. Benner MD</b>		22d. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHARLES M. BENNER ND</b>		22f. ADDRESS <b>1161 NEW HAMPSHIRE AVE SILVER SPRING, MD 20904</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/30/85</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Rock Creek Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Washington, D.C.</b>		COUNTY	STATE		
24. FUNERAL DIRECTOR NAME <b>Francis Gasch's Sons Funeral Home, P.A.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 30 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Julia L. Davidon Pendere</b>							
DHMH - 16 50M 4/B2 (VRA 15, 4)											



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 35149

365110

1 -  
FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME <small>(TYPE OR PRINT)</small>			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR					
<i>Helen M. Hutchens</i>						<i>December 18, 1985</i>				<i>11:31 A</i>					
3. SEX		4 RACE		5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS MONTHS DAYS			
<i>Female</i>		<i>Caucasian</i>		<i>October 9, 1923</i>			<i>62</i>								
7a. BIRTHPLACE <small>(STATE OR FOREIGN COUNTRY)</small>		7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			<small>MD.</small>				
<i>Washington, D.C.</i>		<i>USA</i>			<i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></i>			<i>Montgomery</i>							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <small>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)</small>								12a. USUAL OCCUPATION <small>(TYPE OF WORK FOR MOST OF WORKING LIFE)</small>				12b. KIND OF BUSINESS OR INDUSTRY	
<i>Bethesda</i>		<i>Suburban Hospital</i>								<i>Housewife</i>					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
<i>Maryland</i>		<i>Montgomery</i>		<i>Rockville</i>						<i>4900 Melinda Court 20853</i>					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT (Daughter) 4305 Lescott Street					
<i>Elmer</i>		<i>Buford</i>	<i>Moubray</i>	<i>Lodusky</i>			<i>578-24-5729 Cheryl Solano</i>			<i>Rockville, Md. 20853</i>					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>bronchopneumonia</i>								ADDRESS <small>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</small>					
										<i>5 days</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b).		DUE TO, OR AS A CONSEQUENCE OF													
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(IF EITHER NOTIFY MEDICAL EXAMINER)</small>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED <small>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/></small>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I or the hospital) attended the deceased from <i>March 19, 1983</i> to <i>December 18, 1985</i> , that (I) (we) last saw the deceased alive on <i>Dec. 19, 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If we did not see the body after death,															
22b. SIGNATURE					DEGREE			ATTENDING <input checked="" type="checkbox"/> MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS			<i>11510 Old Georgetown Road</i>		<i>Rockville, Maryland 20852</i>		<i>Dec. 18, 1985</i>			
<i>G. Peter Pushkas, M.D.</i>															
23a. BURIAL, CREMATION, REMOVAL <small>(SPECIFY)</small>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE				
<i>Burial</i>		<i>12/21/85</i>		<i>Parklawn</i>			<i>Rockville</i>		<i>Montgomery</i>		<i>Md.</i>				
24. FUNERAL DIRECTOR NAME		24a. ADDRESS			24b. DATE REC'D. BY REGISTRAR			24c. REGISTRAR'S SIGNATURE							
<i>Francis J. Collins Jr.</i>		<i>500 Univ. Blvd., W., Silver Spring, MD. 20901</i>			<i>DEC 27 1985</i>										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached to use on the burial permit. Then please remove carbon paper. Pages 1 and 2 should be retained with the State Dept. of Health and Mental Hygiene prior to Burial, Cremation, or Removal.

IMPORTANT: If item 21 is marked **admit**, the medical examiner will be notified.

GLASS

358016

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 35 150

REG. NO.

1 - STATE  
REGISTRAR

1. DECEASED NAME <i>Olive L Imirie</i>			FIRST	MIDDLE	LAST	2a. DATE OF DEATH <i>12-13-85</i>	MONTH	DAY	YEAR	2b. HOUR <i>10 AM</i>	
3. SEX <b>Female</b>			4. RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>1894</b> MONTH DAY YEAR <b>October 30,</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE <b>Washington, DC</b>			7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD</b>		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Suburban Hospital</b>			12a. USUAL OCCUPATION <b>Clerk</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Department of State</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Chevy Chase</b>			13d. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE <b>3813 Williams Lane 20815</b>											
14. FATHER'S NAME <b>Charles A. Meyer</b>			15. MOTHER'S MAIDEN NAME <b>Sarah Olive</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>N/A</b>			17. INFORMANT <b>(Son)</b>			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
			16b. SOCIAL SECURITY NO. <b>579-14-0982</b>			17. INFORMANT <b>Scott F. Imirie Chevy Chase, MD 20815</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest.</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) <i>Stroke</i>						Two day.		
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>NO</b> <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>NO</b> <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from ~ <i>3</i> , 19 <i>83</i> , to <i>62 13</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>12-12</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Christopher Unger, MD</i>			22c. DEGREE			22d. DATE SIGNED <b>December 13 1985</b>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Christopher Unger, MD</i>			22f. ADDRESS <i>8218 Wisconsin Ave. Bethesda.</i>			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>December 17, 1985</b>			23c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Suitland</b> COUNTY <b>Maryland</b> STATE		
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A.</b> 7557 Wisconsin Avenue Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR <b>DEC 20 1985</b>			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Pendell</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the funeral director permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18b is marked, or either traumatic event, the medical examiner must be notified immediately.

010266

DATE

TERMS

REB 05/30

365115

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8535151

REG. NO.

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
<i>Alice C JACKSON</i>						<i>12-23-85</i>				<i>9:05 AM</i>				
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)											
<i>Female</i>	<i>Black</i>	<i>02 17 20</i>	<i>65</i>											
7a. PLACE OF DEATH	7b. CITIZEN OF WHAT COUNTRY?	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
<i>Ohio</i>	<i>U.S.A.</i>						<i>Montgomery</i>							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12. USUAL OCCUPATION (GIVE OCCUPATION FOR HOME, OR GIVING PLACE OF DEATH)					13b. KIND OF BUSINESS OR INDUSTRY			
<i>Silver Spring</i>	<i>Holy Cross Hospital</i>					<i>Bethel Clerk Dept. Bpk.</i>								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	13e. STREET ADDRESS, ZIP CODE								
<i>MD</i>	<i>Montgomery</i>	<i>Silver Spring</i>				<i>13320 Park Orchard Dr.</i>								
14. FATHER'S NAME	FIRST	MIDDLE	FIRST	15. MOTHER'S MAIDEN NAME		HIDDEN	LAST							
			<i>Bart.</i>	<i>Alice</i>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO, UNCHECK) <input type="checkbox"/> <input checked="" type="checkbox"/> YES, GIVE WAR RECORDS	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS					APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH						
<i>No</i>	<i>283-16-517L</i>	<i>Burdam R. Jackson</i>	<i>13e)</i>					<i>2 months</i>						
18. CAUSE OF DEATH (Enter only one cause per line for Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <i>lacteal &amp; cancer</i>														
DUE TO, OR AS A CONSEQUENCE OF (b): <i>lungs &amp; sarcoma of abdomen</i>														
DUE TO, OR AS A CONSEQUENCE OF (c):														
3 years														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from say the deceased alive on <i>1985</i> , 19 <i>85</i> , to <i>1985</i> , 19 <i>85</i> , that (I) (we) last viewed the body after death.														
22b. SIGNATURE <i>Bruce A. Silver ad</i> DEGREE														
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>														
22c. DATE SIGNED														
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS												
<i>BRUCE A. SILVER</i>		<i>106 Irving St. Wash. D.C. U.S.</i>												
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION								
<i>Burial.</i>		<i>Dec. 28, 1985</i>		<i>Ft. Lincoln.</i>		<i>CITY OR TOWN</i>		<i>Bladensburg Rd. P. G. Md.</i>						
24. FURNERAL DIRECTOR		25a. ADDRESS		25b. DATE REC'D. BY REGISTRAR		25c. REGISTRAR'S SIGNATURE								
<i>Arthur Vetter</i>		<i>Takoma Funeral Home. 254 Carroll St. N. W. D.</i>		<i>DEC 27 1985</i>										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached from the burial/transit permit. Then please remove carbon papers. Page 4 may be retained by the funeral director, page 3 should be detached from the burial/transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

2153

26 Dec 1968 - 100% chick

30 Dec (1st) - adult seen

2 Jan

2nd chick

1st fledged chick

2nd fledged chick

grew with young chick

6 Jan - nest of Marbled Murrelet 3112-2-882

Marbled Murrelet

364140

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - STATE  
REGISTRAR

1. DECEASED NAME FIRST <u>Donald</u> MIDDLE <u>William</u> LAST <u>Jacobs</u>					2a. DATE OF DEATH MONTH <u>July</u> DAY <u>8</u> YEAR <u>1924</u>	2b. HOUR <u>10:50 AM</u>		
3. SEX <u>Male</u>		4 RACE <u>White</u>	5. DATE OF BIRTH MONTH <u>July</u> DAY <u>8</u> YEAR <u>1924</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>61</u>	IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u> YRS <u>61</u>	IF UNDER 24 HRS HOURS <u>0</u> MIN <u>0</u>	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY <u>Penna.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery County</u>		
10. CITY OR TOWN OF DEATH <u>Bethesda</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Suburban Hospital</u>		12a. USUAL OCCUPATION <u>Management Analyst</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Dept. of Navy</u>		
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>	13c. CITY OR TOWN <u>Potomac</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>9510 Kentsdale Drive 20854</u>		
14. FATHER'S NAME FIRST <u>Frank</u>		MIDDLE <u></u>	LAST <u>Jacobs</u>	15. MOTHER'S MAIDEN NAME FIRST <u>Mary</u>		MIDDLE <u></u>	LAST <u>Butler</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <u>579-20-7194</u>		17. INFORMANT <u>Stepanie M Barger.</u>		ADDRESS <u>Portland, Oregon 16002 S.E. Brooklyn St.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		<u>cardiorespiratory arrest</u>						
		DUE TO, OR AS A CONSEQUENCE OF (b) <u>cerebral hemorrhage</u>						
		DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>12-14</u> , 19 <u>85</u> , to <u>12-19</u> , 19 <u>85</u> , that (I) (we) lost sow the deceased alive on <u>12-19</u> , 19 <u>85</u> , and that in (my) <u>we</u> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								22c. DATE SIGNED <u>12-19-85</u>
22b. SIGNATURE <u>Thomas G. Sanderson, MD</u>		DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Thomas G. Sanderson, MD</u>		22e. ADDRESS <u>11125 Rockville Pike, Rockville, Md. 20852</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		23b. DATE <u>12/20/1985</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Mt. Comfort Crematory</u>		23d. LOCATION CITY/TOWN <u>Alexandria</u> COUNTY <u>Virginia</u> STATE <u></u>			
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons Inc.</u> <u>5130 Wisconsin Ave., N.W. Wash., D.C.</u>		25a. DATE REC'D. BY REGISTRAR <u>DEC 23 1985</u>		25b. REGISTRAR'S SIGNATURE <u>John Sanderson, R.R.D.</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by you, it should be detached for use as the burial permit. Then please send it to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



353066

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8535150

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
<b>ELIZABETH JACOB S</b>				<b>DEC 8 85</b>				<b>6:00 P.M.</b>
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR			IF UNDER 24 HRS	
<b>Female</b>	<b>White</b>	<b>5 / 3 / 1893</b>	<b>92</b>	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <b>XXX</b> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
<b>Colorado</b>	<b>U. S. A.</b>		<b>Montgomery</b>					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
<b>Rockville</b>	<b>Hebrew Home of Greater Washington</b>			<b>Sales Lady</b>		<b>Ladies Apparel</b>		
13a. STATE <b>Maryland</b>								
13b. COUNTY <b>Montgomery</b>								
14. CITY OR TOWN <b>Rockville</b>								
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
13e. STREET ADDRESS, ZIP CODE <b>6121 Montrose Road 20901</b>								
14. FATHER'S NAME	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	MIDDLE	LAST			
<b>Samuel</b>		<b>Ehrlich</b>	<b>Mollie</b>		<b>Rosenkauf</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a), DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE 10 YEARS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO, OR AS A CONSEQUENCE OF (c) <b>ESSENTIAL HYPERTENSION 10+ YEARS</b>					
<b>No</b>	<b>522-05-7873</b>	<b>Dorothy Rosenblatt</b>	<b>1935 Wolfe Street, Denver, Colorado 80204</b>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
5 MIN								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>SEVERE DEMENTIA</b>								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				<b>YES <input type="checkbox"/> XXX</b>	<b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY	STATE		
22a. I certify that I (this hospital) attended the deceased from <b>12/18 1981</b> to <b>12/18 1985</b> , that I (we) last saw the deceased alive on <b>12/18 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did not view the body after death.								
22b. SIGNATURE <b>Steven Lipson</b>								
22c. DATE SIGNED <b>10/9/85</b>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22f. ADDRESS	
<b>STEVEN LIPSON</b>	<b>MD</b>						<b>6121 MONTROSE RD, ROCKVILLE</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION CITY OR TOWN	23e. STATE				
<b>Burial</b>	<b>12/11/1985</b>	<b>B'Nai Jacob Cemetery</b>	<b>Pueblo,</b>	<b>Pueblo, Colorado</b>				
25a. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.	25b. DATE REC'D. BY REGISTRAR <b>DEC 16 1985</b>			25c. REGISTRAR'S SIGNATURE <b>John David Lipson</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. The physician retains page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/transit or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

52969



POST CARD LIBRARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate  
be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please save one copy of pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event like medical examiner might be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																
REG. NO. 365242																
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
ROBERT JOSEPH JAMES												DECEMBER 20 1985			11:22 a.m.	
3. SEX		4 RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
MALE		CAUCASIAN		MONTH DAY YEAR			74			MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
DELAWARE		UNITED STATES		AU GUST 12 1911			MONTGOMERY			99999						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA		NAVAL HOSPITAL										RETIRED		U.S.NAVY		
13a. STATE DELAWARE		13b. COUNTY SUSSEX		13c. CITY OR TOWN SEAFORD			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE RT 1, BOX 337A		19973				
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST				
WILLIAM JAMES							FRANCES WOEHNING									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		(IF YES, GIVE WAR OR DATES) 1945-1971		16b. SOCIAL SECURITY NO. 116-12-1975			17. INFORMANT MARGARET R. JAMES, RT 1, BOX 337A, SEAFORD, DE			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIAC ARREST</b>																
DUE TO, OR AS A CONSEQUENCE OF (c) _____																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 10, 1985, to DECEMBER 20, 1985, that (II) (we) last saw the deceased alive on DECEMBER 20, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Chatoor C.J.</i>		22c. DEGREE MD		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22d. DATE SIGNED 20 DEC 85						
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS NAVAL HOSPITAL, BETHESDA, MD 20814														
G. A. CALLEJA, LT, MC, USNR																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Dec 22, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Odd Fellows Cemetery			23d. LOCATION CITY OR TOWN			CITY OR TOWN		COUNTY		STATE		
Burial							Seaford			Sussex		Delaware				
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Homer L. Disharoon Box 678 Laurel, Del 19956				JUL 26 1985												

standard, 100% of paper produced available this year. Before  
paper for bound books will be required, it would

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO.

35 55

1- STATE  
REGISTRAR Mary H. Jarvis

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED	MONTH	DAY	YEAR	2b. HOUR 1st 2d 3rd
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d HOUR 1st 2d 3rd
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>as per garners</i>		MD.		

10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) <i>Holy Cross House</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>2610</i>		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 2445 Lyttonsville Road		

14. FATHER'S NAME FIRST MIDDLE LAST Sidney Jackson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Chestnut			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. NO 578-09-0327-		17. INFORMANT 2445 Lyttonsville Rd Md. Norman O. Jarvis, Husband, Silver Spring,		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial Dis</i> DUE TO, OR AS A CONSEQUENCE OF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF			
(c)			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.

*None*

19a. DATE OF OPERATION <i>None</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy  Inspection  Inquiry  and in my opinion death resulted from: Natural causes  Accident  Suicide  Homicide  Undetermined manner

ACTUAL SIGNATURE *J. S. Rogers, M.D.* TITLE (SPECIFY) *John S. Rogers, M.D.* MEDICAL EXAMINER DATE SIGNED *Dec 20 1985*

EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 1919 Seminary Rd, Silver Spring, Md.		
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 23 Dec 85	23c. NAME OF CEMETERY OR CREMATORIUM Lincoln Memorial Cemetery, Suitland, P. G. Co., Md.	23d. LOCATION CITY OR TOWN
24 FUNERAL DIRECTOR NAME W. ERNEST JARVIS CO., INC., WASHINGTON, D. C.		ADDRESS	25a. DATE REC'D. BY REGISTRAR DEC 31 1985	25b. REGISTRAR'S SIGNATURE <i>John S. Rogers, M.D.</i>



100 100

BP \_\_\_\_\_

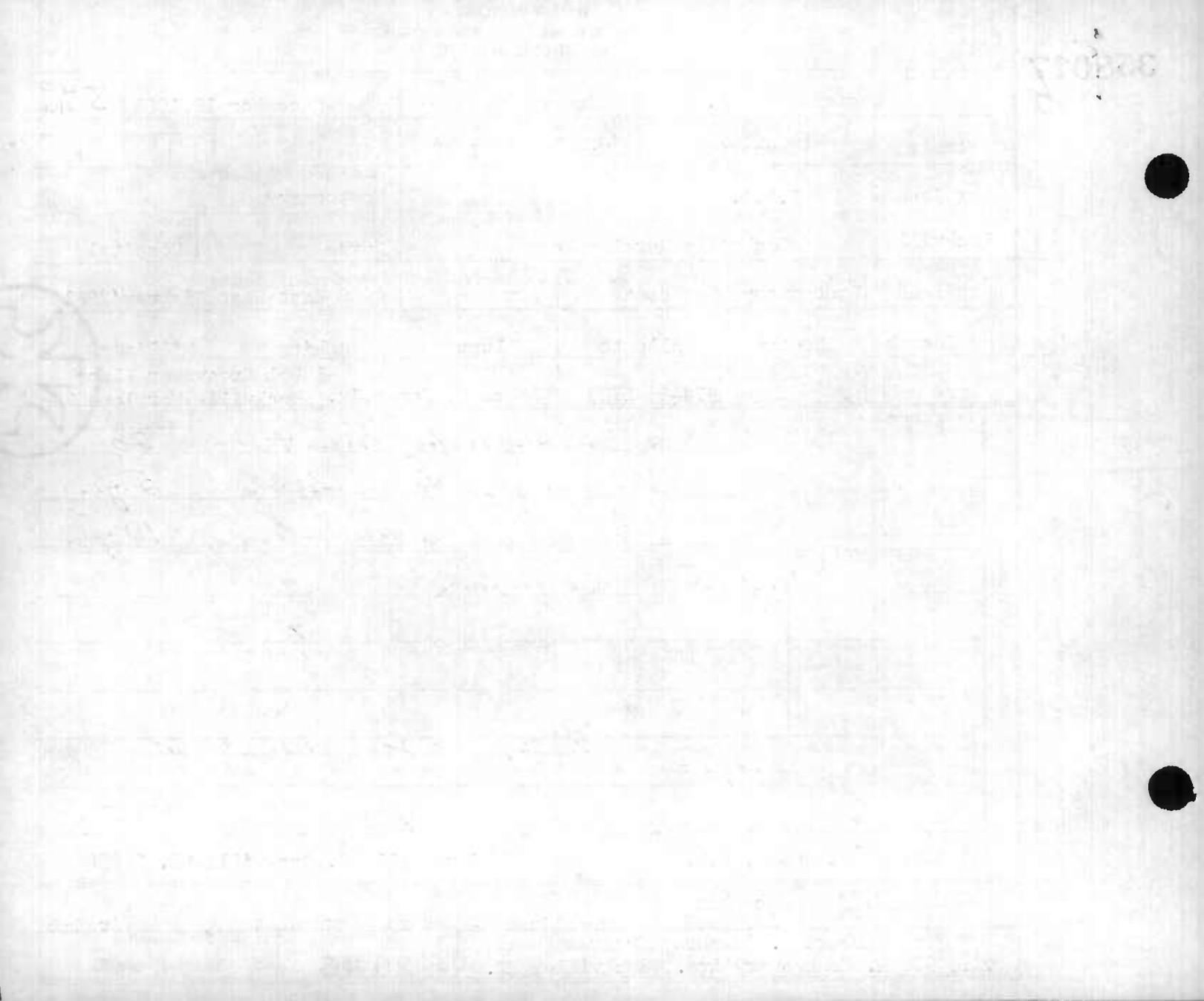
358017

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transit permit. Then please remove carbon patient pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 contains any injury, or other traumatic event, the medical examiner must be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 3 5 1 5						
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
Hester			A.		Jones	December			13, 1985			5:40				
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR					
Female			Caucasian		May 17 1897			88			MONTHS DAYS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8			9			IF UNDER 21 HRS					
Maryland			U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			BALTIMORE CITY OR COUNTY OF DEATH			MONTHS HOURS MIN.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			MD.					
Rockville			Rockville Nursing Home		Nurse			Hospital								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE							
Maryland		Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			4400 East West Highway/20814							
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME													
FIRST Joseph			MIDDLE Newton			LAST Allnutt			FIRST Lucy			MIDDLE White			LAST Williams	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-46-1728			17. INFORMANT Horace T. Jones, Jr.			10201 Grosvenor Place Rockville, Maryland 20852							
18. CAUSE OF DEATH Enter only one cause per line for 18, 1b, and 1c.																
PART I. DEATH WAS CAUSED BY																
IMMEDIATE CAUSE (a) <u>Cardio-respiratory arrest</u>																
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																
(b) <u>Coronary arteriosclerosis</u>																
DUE TO, OR AS A CONSEQUENCE OF																
(c) <u>Generalized arteriosclerosis</u>																
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30'																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN							
22a. I certify that (I) (this hospital) attended the deceased from _____			22b. SIGNATURE <i>Stephen N. Jones, M.D.</i>			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED December 13, 1985							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN N. JONES, M.D.			22e. ADDRESS 809 Viers Mill Rd., Rockville, Md. 20850													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE December 14, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory Alexandria			23d. LOCATION CITY OR TOWN			COUNTY STATE				
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., 300 W. Montgomery Ave., Rockville, MD.						25a. DATE REC'D. BY REGISTRAR DEC 20 1985			25b. REGISTRAR'S SIGNATURE <i>Laurelton Pendleton</i>							



345139

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PEN IN ITEM 1, AND 3 TO THE FUNERAL DIRECTOR.  
**TO FUNERAL DIRECTOR:** PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3 RETAIN PAGE 5 FOR YOUR FILES  
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 35157
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR 3:30 P.M.
Eugene Meyer Joel, Jr.						<input checked="" type="checkbox"/>			Dec. 6	19	85	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN	2c. DATE PRONOUNCED DEAD		
Male	White	Oct. 20 1967	16							Dec. 1	19	85
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH				
Charlotte, N.C.		U.S.A.			<input checked="" type="checkbox"/>			Montgomery				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Towson			Wash. Advent Hosp			Analyst			U.S. Gov't.			
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 20902
Md			Montgomery			S. S. Spg						1634 Belvedere Blvd.
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	Hollander		
Eugene				Joel	Alma					Md. 20902		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
Yes			224-09-5181			Nora Joel; Wife; 1634 Belvedere Blvd.; S. Spg.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial D.I.</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												
(b) <i></i> DUE TO, OR AS A CONSEQUENCE OF												
(c) <i></i>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)												
None			None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
19a. DATE OF OPERATION			19b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21c. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. LOCATION									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>John S. Rogers, M.D.</i> TITLE (SPECIFY) <i>Dep</i> MEDICAL EXAMINER												
EXAMINER'S NAME (TYPE OR PRINT)			JOHN S. ROGERS, M.D.			ADDRESS			DATE SIGNED <i>Dec. 1/1985</i>			
23a. BURIAL, Cremation, Removal (SPECIFY)			23b. DATE 12/3/85			23c. NAME OF CEMETERY OR CREMATORIAL Lee Crematory			23d. LOCATION CITY OR TOWN Washington, D.C.			
Cremation			12/3/85			Lee Crematory			COUNTY			
24. FUNERAL DIRECTOR NAME ADDRESS 1170 Rockville Pike; Rockville, Md.			25a. DATE REC'D. BY REGISTRAR DEC 05 1985			25b. REGISTRAR'S SIGNATURE <i>J. K. K. [Signature]</i>						
DHMH - 17 (VR A15 ME (5))												

821.12

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30 JUNE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or by the attending physician. Then please remove carbon copies. Then please file within 72 hours after death.  
 IMPORTANT: If Item 21 is marked dead, Item 21a is marked dead, and Item 22 is marked dead, then the death certificate will be detached from the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

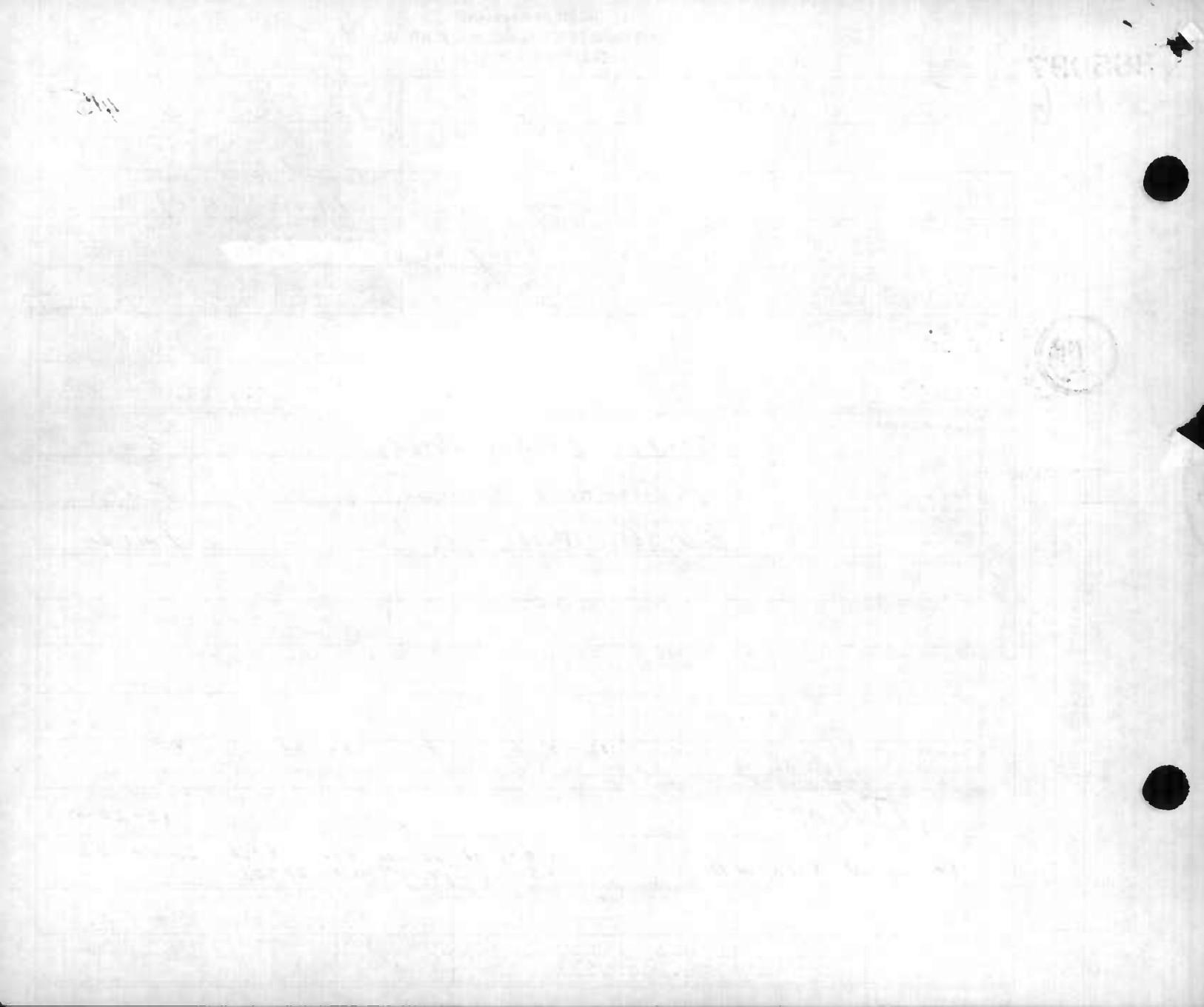
365097

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 35156

REG. NO.

1 - STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
John J. Kaminsky SR.						12-20	85-	45 <sup>A</sup>	M				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				
Male			Caucasian			Aug. 1, 1925			60 yrs				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Pennsylvania			United States						Montgomery County, MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Silver Spring			Holy Cross Hospital			Accountant			Internal Auditor				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE	
Maryland			Montgomery			Gaithersburg						9410 Penshurst Court/20879	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
John			Carol										
FIRST			MIDDLE									LAST	
J.			Jane									Not available	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Yes			WW II			207-16-5411			John J. Kaminsky, Jr., same as #13			5 min	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u>													
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Hepato-Renal Syndrome</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>End Stage Fatty Liver</u>													
5 days													
1 month													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-5 <sup>A</sup> , 1985, to 12-20, 1985, that (I) (we) last saw the deceased alive on 12-19, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Philip W. Poth, M.D.</u>			DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12-20-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 831 University Blvd. East, Suite 32 Silver Spring, Md. 20903										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Dec 20, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crem.			23d. LOCATION Alexandria, Virginia				
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes 300 West Montgomery Ave. Rockville, MD PA						25a. DATE REC'D. BY REGISTRAR DEC 27 1985			25b. REGISTRAR'S SIGNATURE				



Cleaved By Dr. John Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death be reported within 24 hours after death. Page 4 more than 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial permit stamp. Then please return to the Office of Health and Mental Hygiene prior to burial, cremation or entombment.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 35157						
										REG. NO.						
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
			Louis			KAPLAN			12		08	85	1:16 p.m.			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE			White			MONTH DAY YEAR			87			MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Russia			U. S. A.			JAN 26 1898			Montgomery							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring			Holy Cross Hospital			Delicatessen			Owner							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			20910	
Maryland			Montgomery			Silver Spring			YES			1220 Blair Mill Road, Apt. 404				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST			FIRST MIDDLE LAST													
Abraham Isaac Kaplan			Yetta Schick													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
No			578-20-8484			Dorothy Flax			1220 East West Highway, Apt. 709 Silver Spring, Maryland 20910							
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
IMMEDIATE CAUSE (a) CARDIAC ARREST										15 MINUTES.						
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b) coronary artery disease						
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
Cause			Obstructive			Pulmonary			Injury							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from January 19, 1985, to Dec. 8, 1985, that (I) (we) lost saw the deceased alive on Nov. 19, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			12-09-85				
Dr. G. Braun			MD													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			717 Preston Dr. Silver Spring Md 20910										
Dr. G. Braun																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION							
Burial			12/10/1985			B'Nai Israel Cong.			Oxon Hill, P. G., Md.							
24. DIRECTOR										25. DATE REC'D. BY REGISTRAR		26. REGISTRAR'S SIGNATURE				
DONALD A. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.										Dec. 12, 1985		John Johnson				

32312



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the burial permit. Then phone, remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 35160			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST Madeleine	MIDDLE A	LAST Kennedy	2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR			
Madeleine A		Kennedy			12/11/85					10:30 AM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Female		White		MONTH //	DAY /	YEAR 95	90			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Wash DC		USA					Montgomery						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)											
Silver Spring		Carriage Hill Nursing Center											
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9101 Second Ave. 20910				
14. FATHER'S NAME FIRST Charles		MIDDLE G.	LAST Harper			15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE			LAST Dacey		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. ADDRESS			17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ischemic heart disease				
No		579-60-5923		Bethesda, Md.			Mary Rita Renauer.		6610 Greyswood Rd.,				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
(b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a multiple myeloma													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT HOME <input type="checkbox"/> NOT WHILE AT HOME <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from October 19 85 to December 19 85, that (I) (we) last saw the deceased alive on 12-3 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Barbara Blaylock, M.D.		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 12-11-85					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Barbara Blaylock, M.D.		22f. ADDRESS 6111 Executive Blvd, Rockville, MD 20852											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/14/1985		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery			23d. LOCATION Washington, D.C.		25a. DATE REC'D. BY REGISTRAR DEC 16 1985				
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 1/2 Wisc. Ave., N.W. Wash., D.C.		25b. REGISTRAR'S SIGNATURE John Johnson Pendell											
ADDRESS													

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENNANT LETTERS ON PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AS A BURIAL TRANSIT FORM ALONG WITH FORM PH-1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT FORM ALONG WITH FORM PH-1. RETAIN PAGE 2 FOR YOUR FILES. PAGE 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

365295

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 35161

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>ARMON</i>	MIDDLE <i>EUGENE</i>	LAST <i>KERNS</i>	2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> DEATH 12 12 85 19	MONTH JULY 19	DAY 12	YEAR 85	2b. HOUR 11:25 AM
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>June 5 1942</i>	6. AGE (IN YEARS (LAST BIRTHDAY) <i>43 (3 yrs.)</i>	IF UNDER 1 YR. MONTHS DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD 12 12 85 19	MONTH JULY 19	DAY 12	YEAR 85	2d. HOUR 11:25 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Ohio</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i>							
10. CITY OR TOWN OF DEATH <i>Rockville</i>	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Shady Grove Adventist Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Lineman/Pot. Ed.</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Frederick</i>	13c. CITY OR TOWN <i>Thurmont</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET ADDRESS <i>112 Frederick Road</i>						
14. FATHER'S NAME FIRST <i>Herbert</i>	MIDDLE <i>Eugene</i>	LAST <i>Kerns</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Pearl</i>	MIDDLE <i>Tigner</i>	LAST <i>112 Frederick Rd.</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input checked="" type="checkbox"/> YES	16b. SOCIAL SECURITY NO. <i>Viet Nam 277-38-6179</i>	17. INFORMANT <i>Mrs. Elizabeth Kerns</i>	ADDRESS <i>Thurmont, Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <i>Cardio Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.  (b) <i>Electrocution</i> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> AM MONTH DAY YEAR <i>12 12 1985</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Electrocution</i>								
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Street</i>	21f. LOCATION STREET <i>Glad Hill Brothers Rd</i>	CITY OR TOWN <i>Brownsburg Rd and</i>	COUNTY <i>Montgomery</i>	STATE <i>Md.</i>					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>John Tauber</i> M.D. <i>Douglas</i> MEDICAL EXAMINER <i>Bethesda</i> ADDRESS <i>218 Wisconsin Ave</i>						DATE SIGNED <i>12-12-85</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>12/16/85</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Blue Ridge Cemetery</i>	23d. LOCATION CITY OR TOWN <i>Thurmont, Frederick, Maryland</i>	23e. COUNTY <i>Montgomery</i>	23f. STATE <i>Md.</i>					
24. FUNERAL DIRECTOR <i>John Tauber</i> <i>R. E. Dailey &amp; Son</i>	25a. DATE REC'D. BY REGISTRAR <i>DEC 23 1985</i>	25b. REGISTRAR'S SIGNATURE <i>Julie Davison-Poole</i>								
DHMH - 17 (VR A15 ME (5))										

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN TO PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												8 5 3 5 1 6 2						
												REG. NO.						
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE KNOWN OF ESTI- DEATH MATED		2b MONTH	DAY	YEAR
		Charles Robert Keyes												<input checked="" type="checkbox"/>		12	2019	85
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR		IF UNDER 24 HRS.		7c DATE PRONOUNCED DEAD		2d MONTH		DAY	YEAR	
MALE		CAUCASIAN		3 10 1941		44 yrs.		MONTHS DAYS		HOURS MIN.		12 2019		5:15PM				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH							
WASHINGTON DC		USA									Montgomery County, MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY										
Bethesda		Suburban Hospital			DIST MANAGER			TIRE SALES										
13a STATE VIRGINIA		13b COUNTY		13c CITY OR TOWN ALEXANDRIA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 519 N ARMISTEAD ST/T2										
14. FATHER'S NAME CLARENCE		MIDDLE B		LAST KEYES		15. MOTHER'S MAIDEN NAME ELEANOR		LAST SNYDER										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT STEPHEN KEYES SAME AS #13a-e		ADDRESS											
NO		264-60-3512																
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>																		
(b)																		
DUE TO, OR AS A CONSEQUENCE OF																		
(c)																		
DUE TO, OR AS A CONSEQUENCE OF																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?													
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <del>XXX</del> MONTH DAY YEAR 1:46 M. 12 2019 85			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
					Driver in auto/auto impact													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street			21f. LOCATION STREET CITY OR TOWN Montrose & Farm Have, Rockville, Mont, MD			COUNTY STATE										
22a. I certify that I took charge of the remains described above and on <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																		
ACTUAL SIGNATURE					TITLE (SPECIFY) M.B. Acting Chief			MEDICAL EXAMINER			DATE SIGNED							
EXAMINER'S NAME (TYPE OR PRINT)		Thomas D. Smith, M.D.			ADDRESS			111 Penn St.			Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL CREMATION		23b. DATE 12/25/85			23c. NAME OF CEMETERY OR CREATORY LEES CREMATORY			23d. LOCATION CITY OR TOWN WASHINGTON			COUNTY DC							
24. FUNERAL DIRECTOR NAME DEMAINE FUNERAL HOMES, INC		ADDRESS ALEXANDRIA, VIRGINIA			25a. DATE REC'D. BY REGISTRAR DEC 30 1985			25b. REGISTRAR'S SIGNATURE John Davidson Pendleton										



38083-4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

358055

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 5 1 6 0

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST LEE	MIDDLE JOSEPH	LAST KIEFFER	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
				Lee J.			Kieffer	12	16	85	6 45 PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
MALE		WHITE		JULY 6, 1931			54		MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				MD.		
IOWA		U.S.A.					MONTGOMERY						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
GAITHERSBURG		Shady Grove Adventist Hospital				PHYSICIST				U.S. GOVT.			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		18928 N MEADOW FENCE RD. 20879			
14. FATHER'S NAME		FIRST NICHOLAS	MIDDLE G.	LAST KIEFFER	15. MOTHER'S MAIDEN NAME		FIRST HELEN	MIDDLE	LAST GRUE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO		485-32-4157		CAROLYN KIEFFER, WIFE, SAME AS ITEM #13									
18. CAUSE OF DEATH (Enter only one cause per line for 18, 19b, and 21c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac - Pulmonary arrest.</i>													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Massive cerebral intra-bleed.</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/12/85 to 12/16/85, that (I) (we) last saw the deceased alive on 12/16/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Hen. O. Clancy</i>		22c. DEGREE				ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>12/17/85</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Henry O. Clancy</i>		22e. ADDRESS 20428 Germantown Rd, Germantown											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 12/18/85		23c. NAME OF CEMETERY OR CREMATORIAL METROPOLITAN CREMATORIAL		23d. LOCATION CITY OR TOWN ALEXANDRIA, VIRGINIA		COUNTY		STATE			
24. FUNERAL DIRECTOR RICHARD RAPP, INC. 1804 T ST., N.W., WASHINGTON, D.C. 20009						25a. DATE REC'D. BY REGISTRAR DEC 20 1985		25b. REGISTRAR'S SIGNATURE <i>Johanna L. Pendle</i>					

JOHN HENRY FLEMING

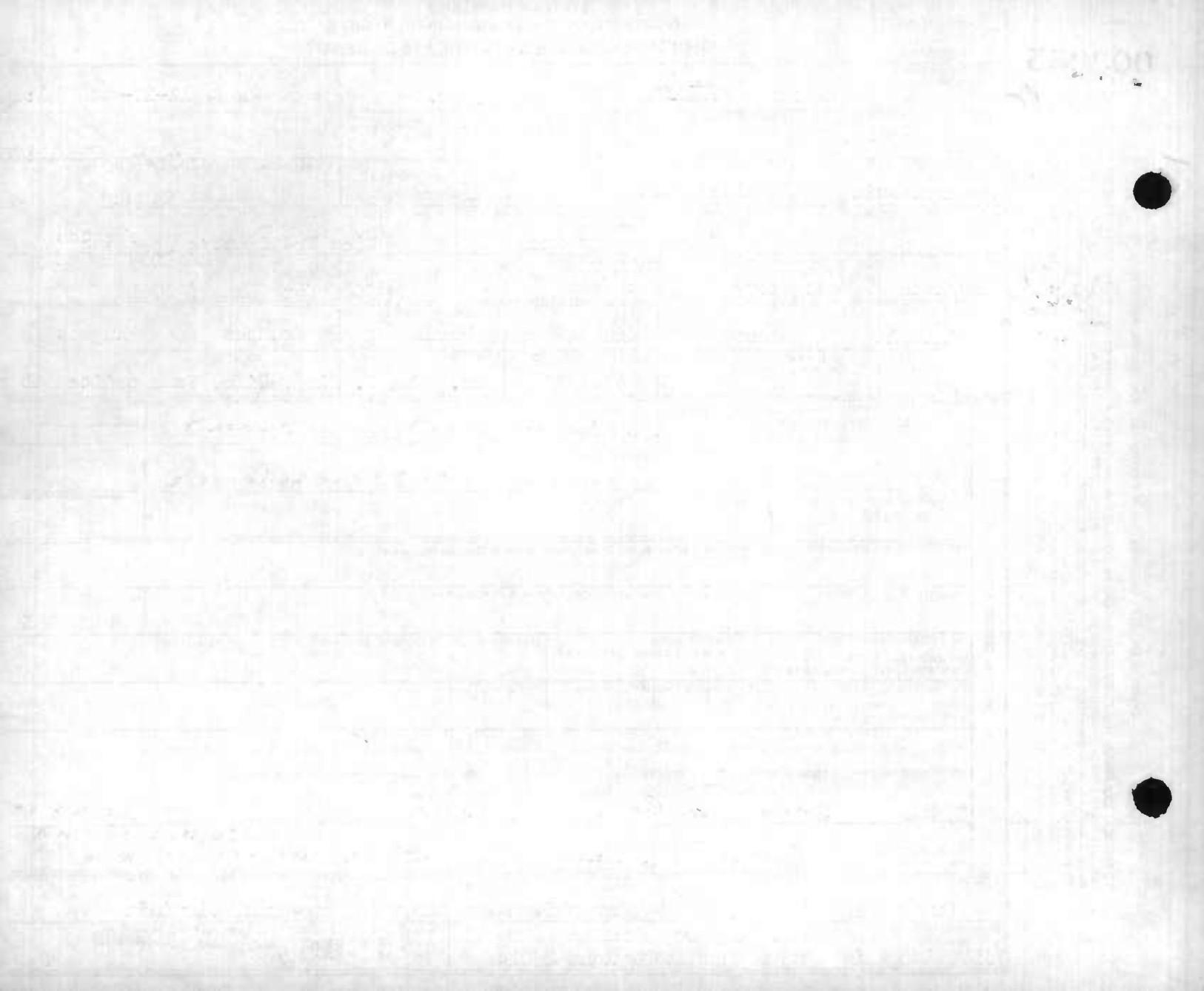
003265

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3516

1-  
FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	7a. DATE KNOWN OF EST. DEATH MATED	MONTH	DAY	YEAR	2b HOUR	
Robert			William		King, Sr.	<input type="checkbox"/>	12-27-	19	85	11:26	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d HOUR	
Male	White	May 28, 1905	80			12-27-	19	85	11:26		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania		United States		<input checked="" type="checkbox"/> NEVER MARRIED	<input type="checkbox"/> DIVORCED	Montgomery County MD					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Suburban Hospital			Vice President/Covering & Roofing Company			Asbestos		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 5605 York Lane / 20814				
14. FATHER'S NAME FIRST William			MIDDLE Joseph	LAST King	15. MOTHER'S MAIDEN NAME FIRST Marie			MIDDLE Frances	LAST Hughes		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR ORDATES)			17. INFORMANT Mrs. Edna S. King, Wife, Same as item 13			ADDRESS		
No			578-05-4559								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <i>Cardio Respiratory arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  DUE TO, OR AS A CONSEQUENCE OF  { Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.  (b) <i>Coronary arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF  (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John Tauber</i>			TITLE (SPECIFY) M.D. <i>John Tauber</i>			MEDICAL EXAMINER			DATE SIGNED <i>12-28-85</i>		
EXAMINER'S NAME (TYPE OR PRINT) <i>John Tauber</i>			ADDRESS <i>218 WISCONSIN AVE</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE December 29, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory			23d. LOCATION CITY OR TOWN Alexandria, Virginia		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes PA 7557 Wisconsin Ave Bethesda, Maryland 20814									23e. REGISTRAR'S SIGNATURE <i>Jean Davidson</i>		
									23f. DATE REC'D. BY REGISTRAR DEC 31 1985		



364072

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 5 1 6 3

REG. NO.

1 - STATE  
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
<b>Martha Ann KLOPER</b>				<b>December 23, 1985</b>	<b>1:30 A.M.</b>
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	
<b>Female</b>		<b>White</b>	<b>Jan. 27, 1937</b>	<b>48</b>	<b>IF UNDER 1 YEAR MONTHS DAYS</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
<b>New York City</b>		<b>American</b>			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<b>Rockville</b>		<b>Shady Grove Adventist</b>			<b>Director</b>
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>20871 12405 Fountain Drive</b>
<b>Maryland</b>		<b>Montg.</b>	<b>Clarksburg</b>		
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
<b>Seymour</b>		<b>Goodman</b>	<b>Pearl</b>	<b>Boyle</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
<b>No</b>		<b>050-32-8650</b>	<b>Kenneth J. Kloper Item 13</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>					
DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASTHMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>9/7</b> , 19 <b>77</b> , to <b>12/23</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>10/23</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Hubert J. Alpert</i>		DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>12/23/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <b>8630 Fenton Street, Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/24/85</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Resthaven Memorial</b>	23d. LOCATION CITY OR TOWN <b>Frederick</b>	COUNTY STATE <b>Maryland</b>
24. FUNERAL DIRECTOR <b>Olin L. Molesworth, P.A., Damascus, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 26 1985</b>		25b. REGISTRAR'S SIGNATURE <i>John W. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial/cremation permit. Then please remove carbon paper. Pages 1 and 2 should be used within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon paper. Then please attach this certificate to the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be attached to the burial/transit permit. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified about it.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified about it.

1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 35111

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Albert			R.		Knott	12	3	85	2:40 PM	
3. SEX	4. RACE	5. DATE OF BIRTH M - MONTH DAY YR --			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN	
Male	Caucasian	1-16-1906			79					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.			Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
Takoma Park		Washington Adventist Hospital			retired					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		
Maryland		Prince Georges		Cheverly		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6208 Kilmer Street, 20785		
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST			
Benjamin			Knott	Mamie			Mallandingham			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
NO		577-01-2865			Lillian M. Knott, Same as Line #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Acute										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hemorrhagic Shock</u> TERMINAL										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>MULTIPLE STRESS Ulcers/erosion - stomach &amp; duodenum</u> 1-2 days										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>ULCERATING CARCINOMA of cecum with Mets to Thoracic Spine (T-12 &amp; T-4) &amp; compression</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 20 Nov 85 to 3 Dec 85, that (we) last saw the deceased alive on 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above we (I did) did not see the body after death.										
22b. SIGNATURE THE PHYSICIAN'S NAME (TYPE OR PRINT)		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/3/85			
Thomas H Bensing		MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE
Burial		12-6-85		Ft. Lincoln Cemetery		Brentwood, P.G., Maryland				
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
F. Gasch's Sons Funeral Home, Hyattsville, Md.					9 1985		John F. Gasch			



343057

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 5 3 5 1 6

1- FOR  
STATE  
REGISTRAR

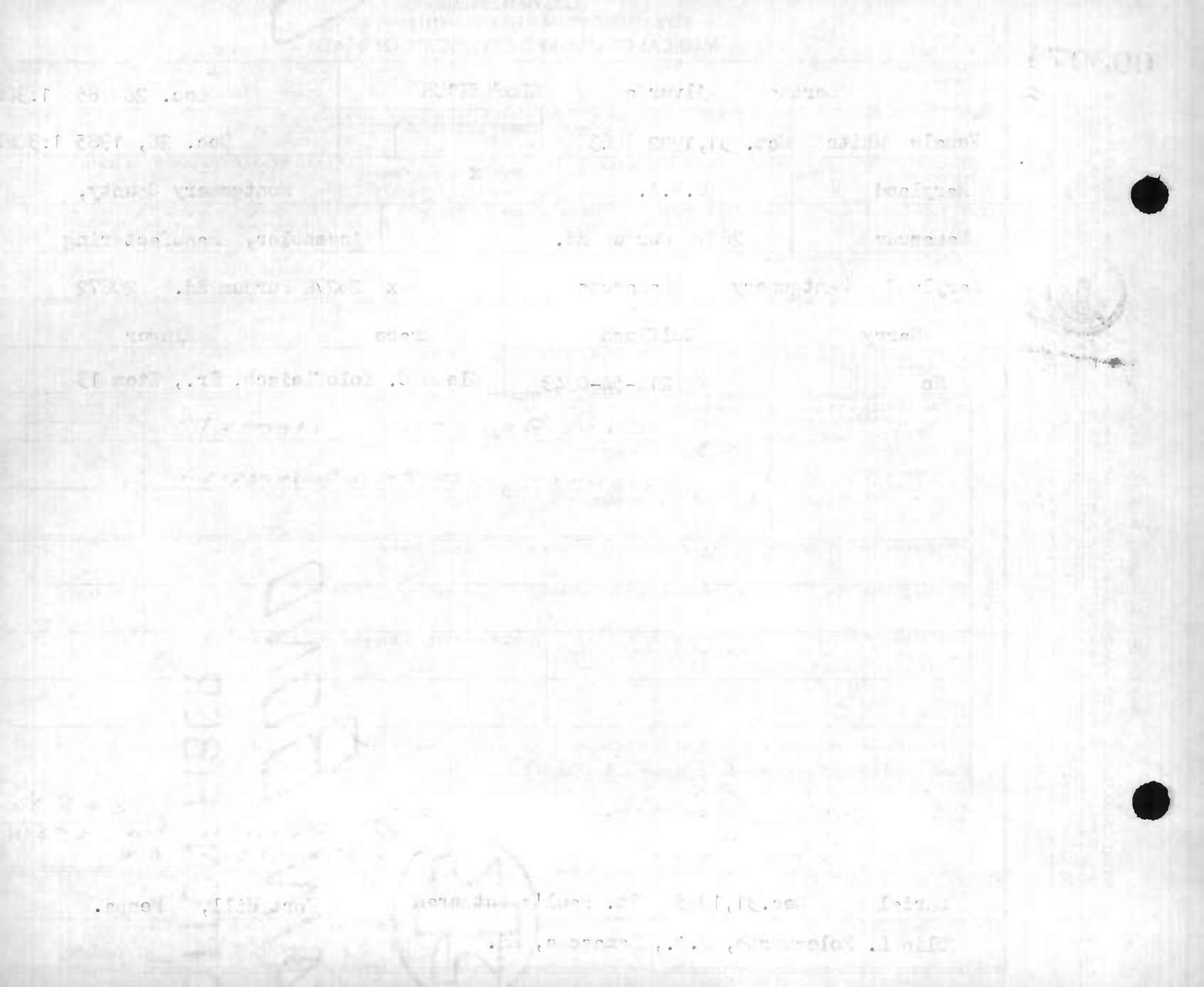
1. DECEASED NAME (TYPE OR PRINT)				2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
MARY FRANCES KOENITZ				DEC. 1 1985	1985	5	10:55 AM	m			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
FEMALE		CAUC.		JAN. 6, 1892		93 YRS.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
MO.		USA						MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY					
ROCKVILLE		POTOMAC VALLEY NURSING CENTER		SALESPERSON		RETAILLED STORE					
13a. USUAL RESIDENCE IF HAVING HOME OR OTHER INSTITUTION. GIVE RESIDENCE BEFORE ADMISSION				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		204B			
MD.		13b. COUNTY		13c. CITY OR TOWN		5239 Strathmore Avenue					
MONT.		ROCKVILLE									
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT			
DAVID				MARGARET		494-01-2306		MARY MARGARET McMAHON			
NO				MIDDLE T. O'CONNELL				13e DAUGHTER			
18. CAUSE OF DEATH Enter only one cause per line for 1a, (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				19. DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardiovascular Disease 15 years		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(c) with Congestive Heart Failure & Hemiplegia							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/11/1984 to 12/2/1985, that (I) (we) last saw the deceased alive on 11/30/1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE				22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 12/2/85			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)				MICHAEL HEALY		ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
BURIAL		DEC. 6, 1985		CALVARY CEMETERY		ST. LOUIS		MO.		MARYLAND	
24. FUNERAL DIRECTOR NAME				25a. DATE		25b. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			
FRANCIS J. COLLINS JR. SILVER SPRING MD.				DEC. 5 1985							
DHMH - 16 60M 7/84 (VRA 15, 4)											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE IT TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3 WHICH SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1A AND 1B SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 5 3510
1- STATE REGISTRAR 003074												
1. DECEASED NAME (TYPE OR PRINT)		FIRST Bertha	MIDDLE Alverda	LAST KOLBFLEISCH	2a. DATE KNOWN OF ESTI- DEATH MATED				MONTH Dec. 28	DAY 1985	YEAR 1:30PM	
3. SEX Female		4. RACE White	S. DATE OF BIRTH MONTH DAY YEAR Oct. 31, 1922	6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN	2b. HOUR			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Damascus		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 26270 Purdum Rd.					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembler, Manufacturing			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Damascus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 26270 Purdum Rd. 20872				
14. FATHER'S NAME FIRST Harry		MIDDLE	LAST Colflesh	15. MOTHER'S MAIDEN NAME FIRST Grace		MIDDLE	LAST Ringer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) No		17. INFORMANT Glenn C. Kolbfleisch, Sr., Item 13		ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <i>Cardio Respiratory arrest.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Coronary arteriosclerosis.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>John Tauber</i>		TITLE (SPECIFY) M.D. <i>Douglas Tauber</i>		MEDICAL EXAMINER <i>Bethesda, Md. 20814</i>		DATE SIGNED <i>12-28-85</i>						
EXAMINER'S NAME (TYPE OR PRINT) John Tauber		ADDRESS <i>8218 WISCONSIN Ave</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 31, 1985		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Lutheran		23d. LOCATION CITY OR TOWN Fort Hill, Penna.		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, ADDRESS P.O. Box 1100, Damascus, Md.		25a. DATE REC'D. BY REGISTRAR DEC 31 1985		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>								
BP												
DHMH - 17 (VR A15 ME (5))												
20M 4/B2												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbonpaper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.		
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Agnes Helen Kowalski									DECEMBER 6 1985			7:30 P M		
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR August 21, 1899			6. AGE (IN YEARS LAST BIRTHDAY) 86			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery			MD.		
10. CITY OR TOWN OF DEATH Kensington			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Circle Manor Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Kensington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 3501 Nimitz Road 20895		
14. FATHER'S NAME FIRST MIDDLE LAST John J. Rudnick			15. MOTHER'S MAIDEN NAME Mary			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 577-58-3616			17. INFORMANT (Daughter) ADDRESS Evelyn M. Dillon Same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LCBAR PNEUMONIA</u>			DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC LYMPHOCYTIC LEUKEMIA</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS								
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last			(c)									YEARS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 22, 1982</u> , to <u>Dec 6, 1985</u> , that (I) (we) last saw the deceased alive on <u>DEC 6, 1985</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did/did not view the body after death.														
22b. SIGNATURE <u>Martin C Sharpe</u>			DEGREE M.D.			22c. DATE SIGNED <u>12/6/85</u>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MARTIN C SHARPE</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS 3720 FARRAGUT AVE. KENSINGTON, MD - 20895								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 10, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven			23d. LOCATION CITY OR TOWN Silver Spring MONT. Maryland					
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. ADDRESS 500 University Blvd. W., Silver Spring, Md. 20901						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <u>Richardson-Pendleton</u>					



20%  
COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Retain this copy until 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR	
				Edna	F.	Kratz	DEC. 9, 1985				2:20 PM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
FEMALE		WHITE		MONTH DAY YEAR			96			IF OVER 24 HRS.		
7a. BIRTHPLACE (ESTATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN.		
maryland		USA		JUNE 6, 1889			MONTGOMERY CO.			MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
ROCKVILLE		NATIONAL LUTH. HOME					HOMEMAKER			HOMEMAKING		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
MARYLAND		BALTIMORE		BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			3200- ECHODALE AVE.			
FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
THOMAS H. MITCHELL				GERTRUDE HECKMAN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
NO		215-24-2486		REV. DR. RICHARD REICHARD-		NLH, ROCKVILLE						
18. CAUSE OF DEATH (Enter only one cause per line for part I, II, and III) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic Heart Disease						
{ DUE TO, OR AS A CONSEQUENCE OF (c)						5 yrs.						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 6, 1967</u> to <u>Dec. 9, 1985</u> , that (I) (we) last saw the deceased alive on <u>Dec. 6, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
Harold F. McConn, M.D.										12-10-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		
Harold F. McConn, M.D.		3350-16th St. N.W. Washington, D.C. 20010		BURIAL		DEC. 12/85		OAK LAWN CEMETERY		BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
HYSONG CO., INC -1300-N ST., NW WASH., DC				DEC 20 1985		Julia Davidson Pendleton						

CHAMPS



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH PAGES 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 7 AND 8 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 5 35171
1- STATE REGISTRAR												
DECEASED NAME (TYPE OR PRINT)		FIRST John	MIDDLE Robert	LAST Krebill			2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH 12	DAY 5	YEAR 85	2b. HOUR 100 A.M.	
3. SEX Male	4. RACE Caucasian	S. DATE OF BIRTH MONTH DAY YEAR July 7, 1945	6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.	7. IF UNDER 1 YR. MONTHS 0	8. IF UNDER 24 HRS. DAYS 0	9. IF UNDER 24 HRS. HOURS 0	10. IF UNDER 24 HRS. MIN 0	2c. DATE PRONOUNCED DEAD 12 5 85 19	MONTH 12	DAY 5	YEAR 85 19	2d. HOUR 7 30 A.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9307 Wadsworth Drive			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Management Consultant			12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't				
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9307 Wadsworth Drive 20817				
14. FATHER'S NAME FIRST Roland		MIDDLE F.	LAST Krebill			15. MOTHER'S MAIDEN NAME FIRST Nancy		MIDDLE Ruth	LAST Pace			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		16c. INFORMANT (Wife) Kerry L. Krebill			16d. ADDRESS 9307 Wadsworth Dr. Bethesda, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Rheumatic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			19c. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			21d. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. TITLE (SPECIFY) M.D. <u>Deputy</u>			22c. MEDICAL EXAMINER			22d. DATE December 6 1985				
ACTUAL SIGNATURE <u>John Tauber</u>		EXAMINER'S NAME (TYPE OR PRINT) John Tauber			ADDRESS 8218 Wisconsin Avenue, Bethesda, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1985 December 7,			23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory			23d. LOCATION TOWN Alexandria		23e. COUNTY Virginia	23f. STATE Virginia	
24. FUNERAL DIRECTOR NAME P.A. 7557 Wisconsin Avenue, Bethesda, MD		25a. DATE REC'D. BY REGISTRAR DEC 11 1985			25b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>							
DHMH - 17 (VR A15 ME (5))												



365111

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 5 1 / 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
<b>HELMUT F. KUEHNERT</b>						<b>December 19, 1985</b>				<b>3:25 P.M.</b>			
3. SEX		4. RACE	5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
<b>Male</b>		<b>Caucasian</b>	MONTH	DAY	YEAR	<b>51</b>							
7a BIRTHPLACE (COUNTRY)		7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH				
<b>Germany</b>		<b>U.S.A.</b>				<b>Montgomery</b>			<b>Silver Spring</b>				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
13a STATE		13b COUNTY	13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS, ZIP CODE				
<b>Maryland</b>		<b>Montgomery</b>	<b>Wheaton</b>						<b>3318 Claridge Court 20902</b>				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		<b>Otto</b>		<b>Kuehnert</b>	<b>Kati</b>						<b>577-52-3671</b>	<b>Mazie J. Kuehnert</b>	<b>(Wife)</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>			
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes mellitus</b>													
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes mellitus</b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Diabetes mellitus</b>													
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 1984</b> to <b>present</b> , that (I) (we) last saw the deceased alive on <b>Nov 27 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <b>James F. McMurry Jr.</b>		22c. DEGREE <b>M.D.</b>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <b>Dec 19, 1985</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL <b>Metropolitan</b>			23d. LOCATION CITY OR TOWN			23e. ADDRESS <b>Alexandria</b>				
24 FUNERAL DIRECTOR NAME <b>Francis J. Collins, Jr.</b>		24 ADDRESS <b>500 Univ. Blvd., W., Silver Spring, Md. 20901</b>			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <b>DEC 27 1985</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in the presence of a physician. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified in the manner required in the Funeral Director's Handbook, it should be detached for use as the Burial/Transit permit. Then please remove carbon copy, page 1 and attach to the Burial/Transit permit. If you do not have a copy of the Handbook, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 could be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section must be initialed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3535110			
1. DECEASED NAME <b>Roberts B LARSON</b>										2d. DATE OF DEATH 12-27-85			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 - 16 - 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>		IF UNDER 1 YEAR MONTHS DAYS		2d HOUR <b>550 A.M.</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Michigan</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>		10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Lawyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Law</b>			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fernwood House</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>11320 Glen Road. 20854</b>							
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Potomac</b>		15. MOTHER'S MAIDEN NAME <b>Dorothy</b>		16. FATHER'S NAME <b>Oscar John Larson</b>		LAST <b>Roberts</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>199-16-0892 A</b>		17. INFORMANT <b>Dorothy L. Larson, Same as Item 13.</b>		ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Myocardial Infarction      APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)      BETWEEN ONSET AND DEATH Coronary Thrombosis      Sudden Arteriosclerotic Heart Disease      Sudden (c) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cerebrovascular Disease with recent Stroke      10 years													
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Arteriosclerotic Cerebrovascular Disease with recent Stroke													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.      19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET      CITY OR TOWN      COUNTY      STATE									
22a. I certify that (I) (we) attended the deceased from December 6, 1985, to December 27, 1985, that (I) (we) last saw the deceased alive on December 6, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <b>John F. Gustafson</b>		22c. DEGREE <b>M.D.</b>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <b>12-27-85</b>							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John F. Gustafson, M.D.</b>		22f. ADDRESS <b>5480 Wisconsin Avenue, Chevy Chase, Md. 20815</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>12/31/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Comfort Crem.</b>		23d. LOCATION CITY OR TOWN <b>Alexandria, Virginia</b>							
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons Inc.</b> ADDRESS <b>5130 Wisc. Ave., N.W. Wash., D.C.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 3 1986</b>		25b. REGISTRAR'S SIGNATURE <b>JAN 3 1986</b>									

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 5 3 5 1 7 4

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST				2a DATE OF DEATH MONTH DAY YEAR	2b HOUR	
Amanda J. Leavy				12/5/85	8:10 pm	
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
		April 18, 1894		91 yrs.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b CITIZEN OF WHAT COUNTRY? U.S.A.	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery county, MD.			
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Lutheran Home			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Landlady	12b KIND OF BUSINESS OR INDUSTRY realestate	
13a STATE Maryland	13b COUNTY Montgomery	13c CITY OR TOWN Kensington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 10,000 Brunswick Lane 20795		
14. FATHER'S NAME Anton	MIDDLE	LAST Reinfarth	15. MOTHER'S MAIDEN NAME Christina	MIDDLE	LAST oberst	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO) no	(IF YES, GIVE WAR OR DATES)	16b SOCIAL SECURITY NO. 578-42-3628	17. INFORMANT Rev. Richard Reichard Rockville, Md.	ADDRESS 9701 Veirs Drive, Rockville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hysong</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hysong</i>						
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)				
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT HOME <input type="checkbox"/> HOME WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AD HOME, STREET, FACTORY, OFFICE, PARK, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a I certify that (i) this hospital attended the deceased from <i>Dec. 5, 1894</i> to <i>Dec. 5, 1895</i> , that (ii) we last saw the deceased alive on <i>Dec. 5, 1895</i> and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, check (ii))						
22b. SIGNATURE <i>Thomas Boddy M.D.</i>						
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Thomas Boddy M.D.</i>		22d. ADDRESS <i>17904 Georgia Street</i> <i>Owney, MD 20832</i>	22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>	22f. DATE SIGNED <i>12/12/85</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 11, 1985	23c. NAME OF CEMETERY OR CREMATORIAL Prospect Hill Cemetery	23d. LOCATION CITY OR TOWN Washington, D.C.	23e. COUNTY	23f. STATE	
24. FUNERAL DIRECTOR NAME <i>The Hysong Co.</i> ADDRESS <i>1300 N St. N.W. Wash.D.C.</i> DATE REC'D. BY REGISTRAR <i>DEC 12 1985</i> REGISTRAR'S SIGNATURE <i>John Davidson Pendleton</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the medical-attending physician, then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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2000-01-01

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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

3 3 35113

REF. NO.

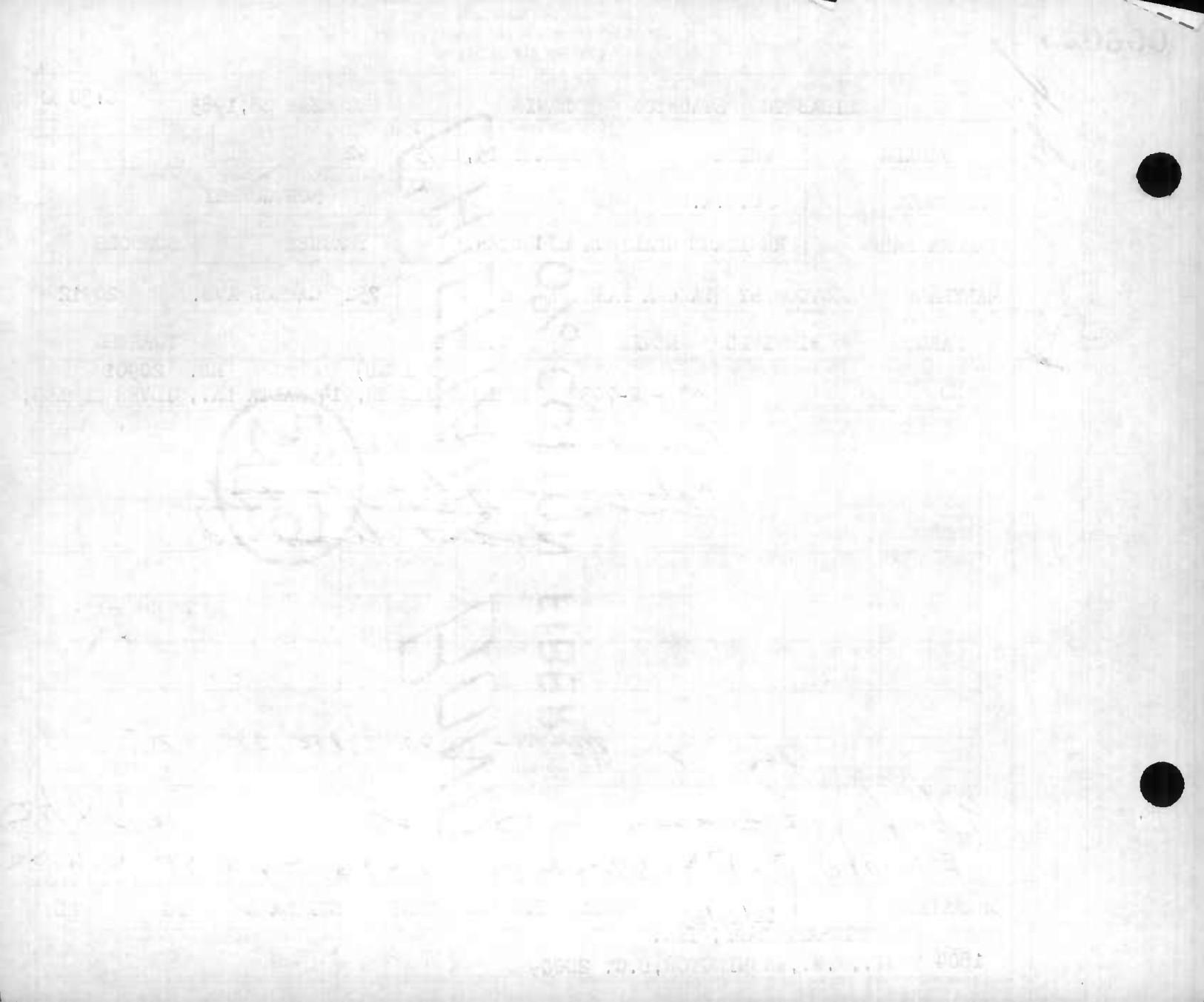
1. DECEASED NAME <small>(TYPE OR PRINT)</small>			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	7b. HOUR		
ELIZABETH STAUNTON LEWIS						DECEMBER	28, 1985			8:30 AM		
1. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7c. IF UNDER 1 YEAR			7d. IF UNDER 24 HR.			
FEMALE	WHITE	MONTH DAY YEAR FEBRUARY 15, 1893	92			MONTHS DAYS			HOURS MIN.			
YRS												
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MINNESOTA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY									
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION THE HERITAGE HEALTHCARE CENTER			12a. USUAL OCCUPATION TEACHER			12b. KIND OF BUSINESS OR INDUSTRY SCHOOLS					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN TAKOMA PARK	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7525 CARROL AVE. 20912								
14. FATHER'S NAME FIRST MARCUS	MIDDLE WINFIELD	LAST LEWIS	15. MOTHER'S MAIDEN NAME CATHERINE		16. SOCIAL SECURITY NO. 578-52-7033		17. INFORMANT (FRIEND) KATHLEEN BECKER, 914 MALTA LA., SILVER SPRING, MD.	ADDRESS MD. 20901				
18. CAUSE OF DEATH (Enter only one cause per line for 18, then enter PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE 18.)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause 18, stating the underlying cause first. (b) <i>A stroke caused the heart disease and caused death</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Heart disease</i>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(IF EITHER, NOTIFY MEDICAL EXAMINER)</small>	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY		STATE					
22a. I certify that (1) this hospital attended the deceased from <i>MAY 10, 1980</i> , to <i>DEC 28, 1981</i> , that (2) we lost <i>the deceased alive on DEC 28, 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We shall not sign the body after death.)											22g. DATE SIGNED <i>12/28/81</i>	
22h. SIGNATURE <i>Edward J. Pacowski</i> DEGREE <i>MD</i>											22i. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22j. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Edward J. Pacowski</i>											22k. ADDRESS <i>1712 Eye St. N.W.</i>	
23a. BURIAL, CREMATION, REMOVAL CREMATION	23b. DATE 12/29/85	23c. NAME OF CEMETERY OR CREMATORIAL CEDAR HILL CREMATORIAL	23d. LOCATION SUTTLAND PG	25a. DATE REC'D. BY REGISTRAR JAN 02 1986							25b. REGISTRAR'S SIGNATURE <i>Jane Gardner-Pendell</i>	
24. FUNERAL DIRECTOR RICHARD RAFF, INC.	ADDRESS 1804 T ST., N.W., WASHINGTON, D.C. 20009											

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HOSPITAL OR ATTENDING PHYSICIAN The

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filed in the funeral director's office, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 must be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP



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UNKNOWN #84-96

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "HOLDING" IN PENCIL IN THE SPACES PROVIDED ON PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER LONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSITORY FORM. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PINESTREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PINESTREET, BALTIMORE, MD. 21201

1- FOR  
STATE  
REGISTRARI. DECEASED NAME  
(TYPE OR PRINT)FIRST  
GEORGE

MIDDLE

LAST

2a. DATE KNOWN  
OF  
DEATH  
ESTI-  
MATEDMONTH  
DAY  
YEAR

2b. HOUR

12-3/4-1984

M

3. SEX

Male

4. RACE

Bl.

5. DATE OF BIRTH

MONTH  
2---8--54  
DAY  
YEAR6. AGE (IN YEARS  
LAST BIRTHDAY)

30 YRS.

IF UNDER 1 YR.

MONTHS  
0  
DAYS  
0

IF UNDER 24 HRS.

HOURS  
0  
MIN.  
02c. DATE  
PRONOUNCED  
DEADMONTH  
12  
DAY  
4  
YEAR  
19842d. HOUR  
4:15  
p.m.7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

Jamaica

7b. CITIZEN OF WHAT COUNTRY?

Jamaica

8. MARRIED  
WIDOWED  
DIVORCEDXX  
□  
□

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County

MD.

10. CITY OR TOWN OF DEATH

Burtonsville

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

construction site - Brownstone Rd.

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)

Unemployed

13a. STATE

D. C.

13b. COUNTY

DC

13c. CITY OR TOWN

Washington

13d. INSIDE CITY LIMITS?  
YES XX  
NO □13e. STREET ADDRESS  
6422 8th St. N. W.

14. FATHER'S NAME

FIRST  
VincentMIDDLE  
Lewis

LAST

15. MOTHER'S MAIDEN NAME

FIRST  
EleanorMIDDLE  
V.LAST  
Lewis16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)  
YES

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.  
579-76-3384

17. INFORMANT

A12422  
6422 8th St. N. W.

Eleanor V. Lewis Washington, D. C.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Perforating gunshot wound of head (unspecified weapon)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.{ (b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20 AUTOPSY?

YES XX  
NO □21a. EXTERNAL CAUSE WAS  
UNDERLYING XX OR  
CONTRIBUTING □ CAUSE OF DEATH21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
? P.M. 12-3/4- 1984

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

Subject shot.

21d. INJURY OCCURRED  
WHILE □ NOT WHILE XX  
AT WORK □ AT WORK21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)  
found at site21f. LOCATION  
STREET  
CITY OR TOWN  
Brownstone Rd. Burtonsville, Montgomery, Md.

22a. I certify that I took charge of the remains described above, held an

Autopsy XX Inspection □ Inquiry □ and in my opinion

death resulted from: Natural causes □ Accident □ Suicide □ Homicide XX Undetermined manner □

ACTUAL  
SIGNATURE

Ann M. Dixon, M.D.

TITLE (SPECIFY)

M.D. Assistant MEDICAL EXAMINER

DATE SIGNED 12-5-84

EXAMINER'S NAME  
(TYPE OR PRINT)

ADDRESS 111 Penn St., Balto., Md. 21201

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION  
CITY OR TOWN

COUNTY STATE

Burial

12/11/84

Lincoln Memorial Cemetery

Suitland P.G.

Maryland

24. FUNERAL DIRECTOR  
NAME

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Sam Gutier Inc. 716 Kennedy St. N.W.-D. C.

DEC 12 1985

Julia Dixon-Parker

BP

07/84

25/84

DHMH - 17

(VR A15 ME (5))

21 DEC

2010-01-01 08:56:00

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3611041 / 35111

REG. NO.

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>JAMES MONROE LEWIS</i>						<i>12-21-85</i>				<i>7:55 P.M.</i>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 12 HRS	
Male		Cauc.		MONTH	DAY	YEAR	65	MONTHS	MONTHS	YEARS	HOURS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
<i>Georgia</i>		<i>U.S.A.</i>								<i>Montgomery</i>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK OR TRADES OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
<i>Takoma Park</i>		<i>Washington Adventist Hospital</i>		<i>Salesman</i>		<i>Air Products</i>					
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
<i>Md.</i>		<i>P.G.</i>	<i>Lanham</i>			<i>5313 Baker Place 20706</i>					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST				
<i>Robert</i>			<i>Lewis</i>	<i>Margaret</i>			<i>Drury</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
No		<i>256-16-3693</i>		<i>James R. Lewis</i>		<i>12305 Guinevere Rd. Glendale, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<i>Adenocarcinoma of lung with metastases to brain, liver, bones, and supraclavicular lymph nodes</i>								<i>4 mos</i>			
DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (the hospital) attended the deceased from <i>Sept. 19 81</i> to <i>Dec. 19 81</i> , that (I) (we) lost saw the deceased alive on <i>12/21/85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I) (did not) view the body after death.								22c. DATE SIGNED <i>12-22-85</i>			
22b. SIGNATURE <i>John Jepko</i>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME <i>John Jepko</i>		22e. ADDRESS <i>8826 Woodyard Rd #201 Clinton, Md 20735</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE <i>12/26/85</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Ft. Lincoln Cem.</i>		23d. LOCATION CITY OR TOWN <i>Brentwood, Md.</i>		23e. COUNTY <i>Prince George's Co.</i>		STATE	
24. FUNERAL DIRECTOR <i>Rendon/Hale Lanham Funeral Home 9013 Annapolis Rd. Lanham, Md. 20706</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 24 1985</i>		25b. REGISTRAR'S SIGNATURE <i>John Rendon</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then attach the carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP \_\_\_\_\_

CONFIDENTIAL

GOVERNMENT



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 3 hours after death and should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon papers. Please do not attach to the burial-transit permit. Then please remove carbon papers. Please do not attach to the burial-transit permit.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												85 35178							
FOR STATE REGISTRAR			REG. NO.																
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR							
R. Walter Linthicum						December 3, 1985						8PM M							
3. SEX			4 RACE		5 DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			Caucasian		Nov. 1 1925						60			YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input checked="" type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland			United States									Montgomery County							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Rockville			13002 Freeland Road									Antique Dealer			Antiques				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 13002 Freeland Road/ 20853								
14. FATHER'S NAME			FIRST George	MIDDLE F.	LAST Linthicum	15. MOTHER'S MAIDEN NAME			FIRST J.	MIDDLE Madeline	LAST Walter								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. no			17. INFORMANT			ADDRESS Wheaton, Md. 20902										
			218 16 0794			Michael B. Linthicum, 11409 Kenton Place,													
18. CAUSE OF DEATH Enter only one cause per line for item 18, Part I and Part II. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Metastatic adenocarcinoma</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>colon adenocarcinoma</i>																			
DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death												22c. DATE SIGNED December 4 1985							
22b. SIGNATURE 			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. L. Bucy			22e. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Dec. 7, 1985			23c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven Cemetery			23d. LOCATION CITY OR TOWN Silver Spring			COUNTY	STATE						
Burial																			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, 300 W. Montgomery Av., Rockville, Maryland						25a. DATE REC'D. BY REGISTRAR DEC 9 1985			25b. REGISTRAR'S SIGNATURE 										

COLLEGE LIBRARY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

358071

1. FOR  
STATE  
REGISTRAR

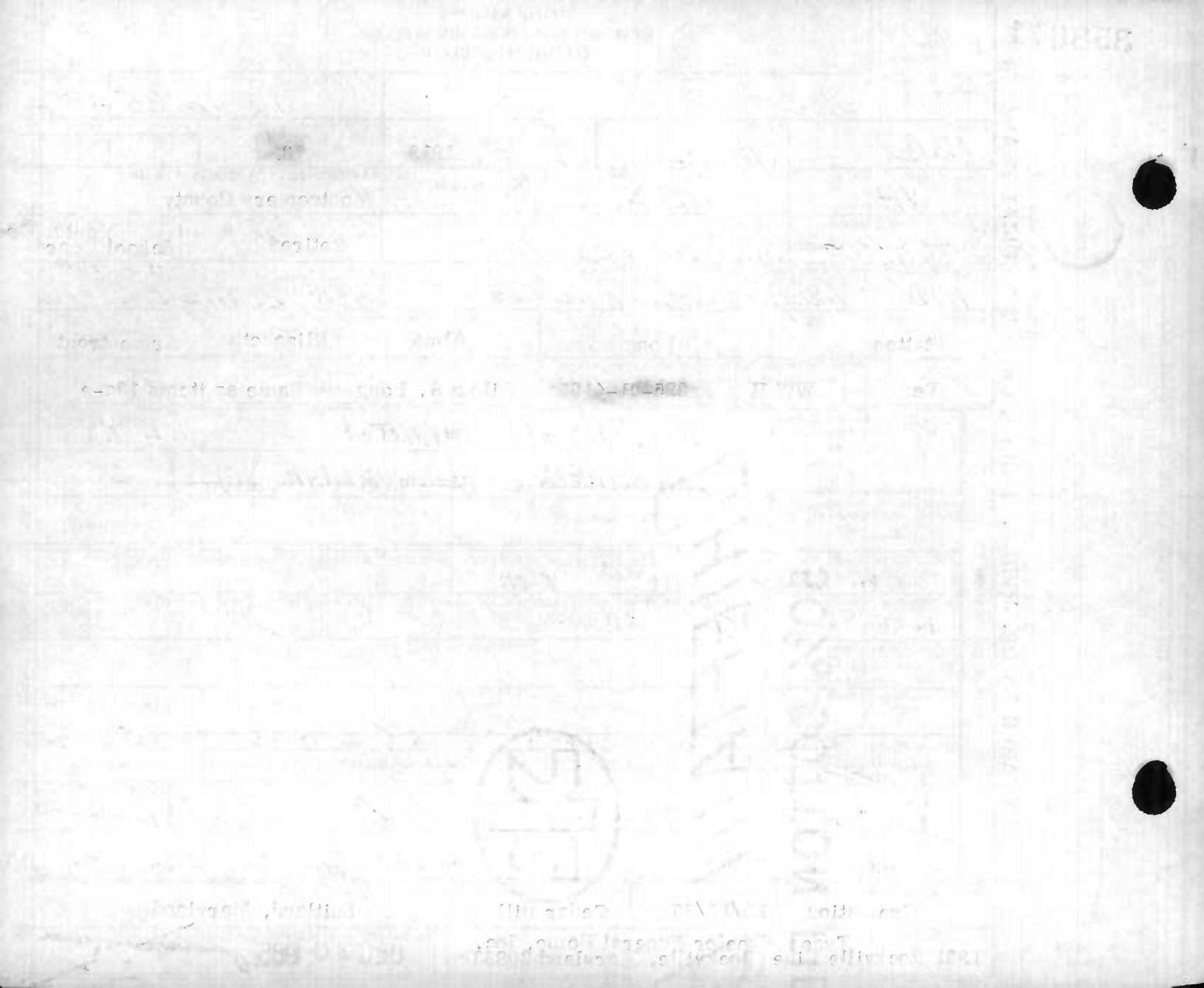
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 35 179

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Cleo</i>	MIDDLE <i>B.</i>	LAST <i>Long</i>	2a. DATE OF DEATH MONTH DAY YEAR	MONTH 12 16 85	DAY YEAR	2b. HOUR 4:25 A.M.		
3. SEX <i>Male</i>			4. RACE <i>White</i>	5. DATE OF BIRTH MONTH 1 DAY 26 YEAR 1912		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>VA</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i>		IF UNDER 24 HRS HOURS MIN.		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN WHICH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Montg. Co. School Board</i>			
13. STATE <i>MD</i>			13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Rockville</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>4800 Boiling Brk. Pkwy</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs.</i>		
14. FATHER'S NAME FIRST <i>Stattan</i>			MIDDLE <i>Long</i>	LAST	15. MOTHER'S MAIDEN NAME FIRST <i>Alma</i>		MIDDLE <i>Elizabeth</i>	LAST <i>Armentrout</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>			16b. SOCIAL SECURITY NO. <i>WW II 225-01-4195</i>		17. INFORMANT <i>Wilma A. Long</i>		ADDRESS <i>Same as items 13a-e</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerotic cardiovascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i></i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>Carcinoma - sigmoid Colon</i>											
19a. DATE OF OPERATION <i>12-11-85</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>SEE ABOVE</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (the hospital) attended the deceased from <i>12-11-85</i> to <i>12-15-85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. The deceased died on <i>12-15-85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <i>Richard L. Colton</i>		22c. DEGREE <i>MD</i>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>12-16-85</i>					
22e. ADDRESS <i>2101 MEDICAL PARK DR. SILVER SPRING MD.</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>12/17/85</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill</i>		23d. LOCATION CITY OR TOWN <i>Suitland, Maryland</i>		COUNTY	STATE		
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home, Inc.</i> <i>1331 Rockville Pike Rockville, Maryland 20852</i>					25a. DATE REC'D. BY REGISTRAR <i>DEC 20 1985</i>		25b. REGISTRAR'S SIGNATURE <i>J. W. Anderson</i>				

BP \_\_\_\_\_



345150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or the item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1 - STATE REGISTRAR			2a. DATE OF DEATH			MONTH DAY YEAR	2b. HOUR
I. DECEASED NAME FIRST MIDDLE LAST			DECEMBER 5, 1985			7:00 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
7a. BIRTHPLACE STATE OR FOREIGN MAINE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		MARCH 28, 1923		62 IF UNDER 1 YEAR MONTHS DAYS	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2100 MARYMONT ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST PEARLIN PARKER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE WILLETT				13e. STREET ADDRESS / ZIP CODE 2100 MARYMONT ROAD 20906	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 264-26-2435		17. INFORMANT CONSTANCE ADLER, DAUGHTER, SAME AS ITEM #13		12b. KIND OF BUSINESS OR INDUSTRY NONE	
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Advanced Breast Carcinoma APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b), DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY STATE
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <u>11-84</u> , 19 <u>85</u> , to <u>currently</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>November 19 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.							
22b. SIGNATURE <i>Patrick J. Byrne MD</i>		22c. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 12/5/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICK J. BRYNE, M.D.		22e. ADDRESS 3800 RESERVOIR ROAD, N.W., WASHINGTON, D.C.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 12/6/85		23c. NAME OF CEMETERY OR CREMATORIAL METROPOLITAN CREMATORIAL		23d. LOCATION CITY OR TOWN ALEXANDRIA, COUNTY VIRGINIA STATE	
24. FUNERAL DIRECTOR NAME 1804 T ST., N.W., WASHINGTON, D.C. 20009				25a. DATE REC'D. BY REGISTRAR DEC 9 1985		25b. REGISTRAR'S SIGNATURE	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

853518

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME <b>ANNE M. LUISTRO</b>			2a. DATE OF DEATH <b>12/31/85</b>	MONTH 12	DAY 31	YEAR 1985	2b. HOUR <b>7:00 PM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>CASL.</b>	5. DATE OF BIRTH MONTH <b>9</b> DAY <b>18</b> YEAR <b>1900</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b>	IF UNDER 1 YEAR MONTHS <b>85</b>	IF UNDER 24 HRS HOURS <b>0</b>	MIN. <b>0</b>	
7a. BIRTHPLACE COUNTRY <b>RI</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b>				
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CARRIAGE HILL OF S.S.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALES PERSON</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>
13a. STATE <b>MD</b>	13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>BETHESDA</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>7420 Westlake Terrace #401</b>		20817	
14. FATHER'S NAME FIRST <b>James</b>	MIDDLE <b>M.</b>	LAST <b>Drew</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Nellie</b>	MIDDLE	LAST <b>McLean</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. <b>035-12-5490-A</b>	17. INFORMANT <b>Americo W. Luistro same as 13e</b>	ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>							
19a. DATE OF OPERATION <b>None</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2 <b>None</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 14, 1985</b> to <b>present</b> , 19_____, that (I) (we) last saw the deceased alive on <b>12/31, 1985</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>John B. Umhoefer MD</b>			DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>12/31/85</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John B. Umhoefer MD</b>			22e. ADDRESS <b>8805 Conn. Ave. Chevy Chase, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>1/3/86</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>National Memorial Park</b>	23d. LOCATION CITY OR TOWN <b>Falls Church, Virginia</b>				
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home, Inc.</b> <b>1331 Rockville Pike, Rockville, Md. 20852</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 8 1986</b>	25b. REGISTRAR'S SIGNATURE <b>John B. Umhoefer</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

rejoined by the hospital or attending physician  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove the carbon copy. Pages 1 and 2 should be filed within 72 hours after death  
 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or  
 important: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner

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ST 1000

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initials, name, date, location, name  
of source, date, place, name

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbons. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other trauma, specify the medical condition must be noted above.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 35182						
										REG. NO.						
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
			Terrance K. Lundy						Dec 2 '85			4 <sup>29</sup> AM				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Male			Black			1 15 56			29			MONTHS DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS				
Pennsylvania			U.S.A.						Montgomery			YRS.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			MD.				
Takoma Park			Washington Adventist Hospital			Director of Foods			ARA Services							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
MD			P.G.			Forestville						6411 Hilmar Drive #103 20747				
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST				
Milton						Lundy			Dorothy			Johnson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			(YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
NO						185-46-1848			Milton Lundy			345 East New Street Glassboro, N.J. 08028				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
DUE TO, OR AS A CONSEQUENCE OF (b) Presumed Pneumocystis carinii pneumonia										MINUTES						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Presumed acquired immune deficiency syndrome										LUCAS months						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from Nov 29, 1985, to Dec 2, 1985, that (I) (we) last saw the deceased alive on Dec 8, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED						
22b. SIGNATURE										Dec 2, 85						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										DEGREE						
James Shaffer MD										ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		
James Shaffer										22e. ADDRESS						
1011 N CAPITAL ST NE										Washington DC 20002						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY		23f. STATE		
Burial			12/6/85			Land of Caanan			Glassboro			New Jersey				
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE		
ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E.										12/6/85				Juliette J. Shaffer		
WASHINGTON, D.C. 20019																

COLLINS FURNITURE HOME INC  
A Division of Homecrest Industries

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be detached for use as the burial/transit permit. Then please remove from this certificate. Item 1 and 2 should be filled within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove from this certificate. Item 1 and 2 should be filled within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8535183											
1. FOR STATE REGISTRAR												REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR											
PHILLIP					LUSTINE	12 17 85			2 PM														
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR												
Male			White		Month Day Year March 15, 1898			87			MONTHS	DAYS	IF UNDER 24 HRS										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH															
Washington, DC			U.S.A.					Montgomery County, MD.															
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY														
Bethesda			Suburban Hospital			Car Dealer (Ret.)			Automobile														
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE												
Maryland			Montgomery		Rockville						5802 Nicholson Lane, #604 (20852)												
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME																	
Abraham					Lustine	First Rachel																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
NO			213-24-3768			Alma Lustine; Wife; 5802 Nicholson Lane, #604;																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infected hematoma</u>																							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Venous malformation in colon with bleeding</u>																							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>and stage renal failure secondary to polycystic kidney disease</u>																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>November 5, 1985</u> to <u>December 16, 1985</u> , that (I) (we) last saw the deceased alive on <u>12/16/1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <u>KNossuli MD</u>															DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>12/17/85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Kaldun Nossuli</u>															22e. ADDRESS <u>11500 dd Georgetown Rd Rockville MD 20852</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 12/19/85			23c. NAME OF CEMETERY OR CREMATORIAL Wash. Hebrew Mem. Park			23d. LOCATION CITY OR TOWN Washington, D.C.			COUNTY			STATE								
Burial																							
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHPLS. 1170 Rockville Pike; Rockville, Md. 20852									25a. DATE FILED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											



351131

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Margaret Brown MacArthur</b>				2a. DATE OF DEATH <b>12/10/85</b>	MONTH <b>Dec.</b>	DAY <b>10</b>	YEAR <b>1985</b>	2b. HOUR <b>7:50p.m.</b>			
3. SEX <b>female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Aug.</b> DAY <b>5</b> YEAR <b>1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>					
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MD.</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Damascus</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>26401 Corner Dr. 20872</b>			
14. FATHER'S NAME FIRST <b>Frederick</b> MIDDLE <b></b> LAST <b>Brown</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Ida</b> MIDDLE <b></b> LAST <b>Wry</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					
16b. SOCIAL SECURITY NO. <b>040-20-8462</b>				17. INFORMANT <b>Lorraine M. Monnier, Item 13</b>				ADDRESS			
18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR 18a, 18b, AND 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Cardiopulmonary arrest</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12/10/85</b>							
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last.  { b) <i>Cardiovascular accident</i>				DUE TO, OR AS A CONSEQUENCE OF  { c) <i>65 Bleeding</i>				11/15/85			
18c. DUE TO, OR AS A CONSEQUENCE OF  { c) <i>65 Bleeding</i>										12/3/85	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)  <b>OMS</b>											
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. <b>—</b> MONTH <b>—</b> DAY <b>—</b> YEAR P.M. <b>—</b> 19 <b>85</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>—</b>		21d. LOCATION STREET <b>—</b> CITY OR TOWN <b>—</b> COUNTY <b>—</b> STATE <b>—</b>					
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>		21g. LOCATION STREET <b>—</b> CITY OR TOWN <b>—</b> COUNTY <b>—</b> STATE <b>—</b>							
22a. I CERTIFY THAT (I) (THIS HOSPITAL) ATTENDED THE DECEASED FROM <b>11/15/85</b> TO <b>12/10/85</b> , THAT (I) (WE) LAST SAW THE DECEASED ALIVE ON <b>12/10/85</b> AT <b>8:00</b> AND THAT IN (MY) (OUR) OPINION DEATH OCCURRED ON THE DATE AND HOUR AND FROM THE CAUSES STATED ABOVE, (I) (WE) DID (DID NOT) VIEW THE BODY AFTER DEATH.											
22b. SIGNATURE <i>Arthur Schoengold, M.D.</i>		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22d. DATE SIGNED <b>12/11/85</b>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Arthur Schoengold, M.D.</b>		22f. ADDRESS <b>18111 Prince Philip Dr., Olney, Md.</b>				23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					
23b. DATE <b>Dec. 14, 1985</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>East Lawn</b>				23d. LOCATION CITY OR TOWN <b>—</b> COUNTY <b>—</b> STATE <b>—</b>					
24. FUNERAL DIRECTOR <b>Olin L. Molesworth, P.A., Damascus, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 13 1985</b>				25b. REGISTRAR'S SIGNATURE <i>—</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 3 5 1 0 5

I. DECEASED NAME (TYPE OR PRINT)			MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR	2b HOUR	
<i>James Sterling C</i>				<i>Madison</i>	<i>12/31/85</i>		
3. SEX <i>Male</i>		4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>10 04 30</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>55</i> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, DC</i>		7b CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i>		
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Inventory Spec</i>		
12b. KIND OF BUSINESS OR INDUSTRY <i>Private Industry</i>				13a. STREET ADDRESS / ZIP CODE <i>2901 18th Street, N. W. #601</i>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>D. C.</i>		13b. COUNTY	13c. CITY OR TOWN <i>Washington</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>3719 Clarington Av, CA.</i>	
14. FATHER'S NAME FIRST <i>James</i>		MIDDLE <i>Allen</i>	LAST <i>Madison</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Carrie</i>		MIDDLE <i>Hillary</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>578-40-5565</i>		17. INFORMANT <i>Yvette P. Madison-Biggins, Dau, Los Angeles,</i>		ADDRESS <i>20 days</i>	
						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Respiratory Arrest</i>				MINUTES	
		DUE TO, OR AS A CONSEQUENCE OF <i>Bilateral Pneumonia, probably Pneumocystis carinii</i>				20 days	
		DUE TO, OR AS A CONSEQUENCE OF <i>Necrotizing Vasculitis</i>				6 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Diabetes mellitus</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 21</i> , 19 <i>85</i> , to <i>Dec 31</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>Dec 31</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (old) (did not) view the body after death							
22b. SIGNATURE <i>James Shaffer MD</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/31/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James F. SHAFFER</i>		22e. ADDRESS <i>1011 North Capital St NE, Washington DC</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>2 Jan 86</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Lee's Crematory</i>		23d. LOCATION CITY OR TOWN <i>Washington, D. C.</i>	COUNTY	STATE
24. FUNERAL DIRECTOR <i>W. Ernest Jarvis Co., Inc., Washington, D.C.</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 3 1986</i>		25b. REGISTRAR'S SIGNATURE <i>John Anderson-Pandell</i>			

999999  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

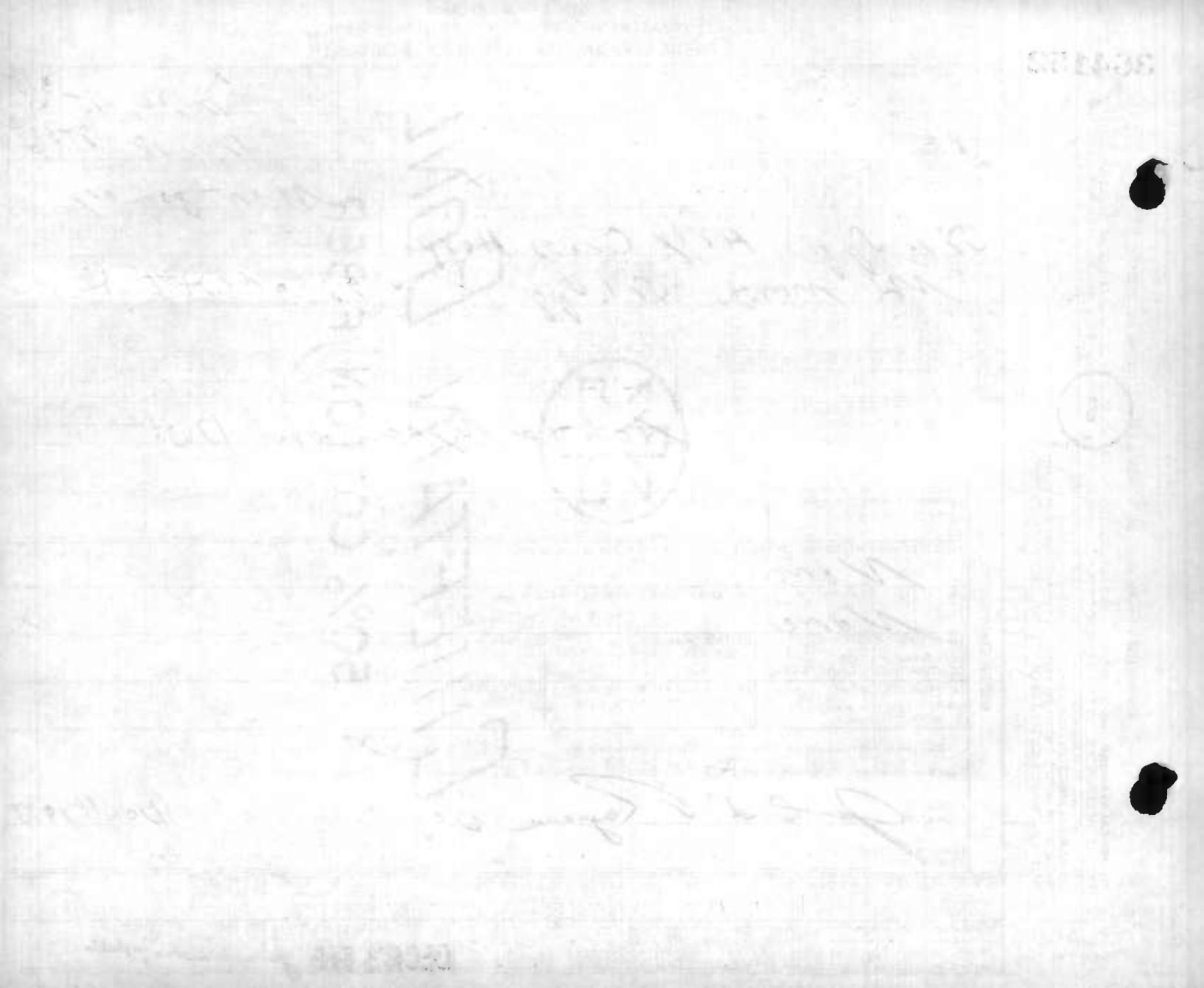
35180

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH CIRCLED PAGE 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. BUSES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)		FIRST SYLVIA	MIDDLE	LAST MAGID	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH Dec 18	DAY 19	YEAR 1985	2b. H 325
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD			2d. M 325
FEMALE	WHITE	AUGUST 20, 1920 65	7RS.			Dec 18 1985			
7a. BIRTHPLACE (STATE OR CITY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH	
NEW YORK		U.S.A.						Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hosp			HOUSEWIFE			OWN HOME	
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	14e. STREET ADDRESS 9829 EAST LIGHT DRIVE		zip--20903.	
14. FATHER'S NAME FIRST ABRAHAM		MIDDLE	LAST SCHWARTZ	15. MOTHER'S MAIDEN NAME FIRST ANNA		16b. SOCIAL SECURITY NO. 125-12-4803		17. INFORMANT JOSEPH MAGID, 9829 EAST LIGHT DRIVE SILVER SPRING, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial Dwi</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i>									
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
22b. TITLE (SPECIFY) <i>John S. Rogers, M.D.</i>									
EXAMINER'S NAME (TYPE OR PRINT)		1919 SEMINARY ROAD			DATE SIGNED <i>Dec 18, 1985</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 12/20/1985		23c. NAME OF CEMETERY OR CREMATORIAL MOUNT LEBANON CEMETERY	23d. LOCATION CITY OR TOWN ADELPHI		PRINCE COUNTY		
24. FUNERAL DIRECTOR <i>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</i>		25a. DATE REC'D. BY REGISTRAR DEC 23 1985		25b. REGISTRAR'S SIGNATURE <i>John S. Rogers, M.D.</i>		STATE GEORGE'S, MARYLAND			
232 CARROLL STREET, N.W., WASHINGTON, D.C.									

27-1506



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

5 35181

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>OLA</b>	MIDDLE <b>Catherine</b>	LAST <b>MAISEL</b>	2a. DATE OF DEATH MONTH <b>Dec</b>	DAY <b>30</b>	YEAR <b>85</b>	2b. HOUR <b>12:45</b>	
3. SEX <b>Female</b>			4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH <b>9</b>	DAY <b>27</b>	YEAR <b>05</b>	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR <b>81</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>			
10. CITY OR TOWN OF DEATH <b>Rockville</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Collingswood Nursing Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a. STATE <b>Md.</b>			13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Silver Spring</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1312 Dennis Ave. 20901</b>			
14. FATHER'S NAME FIRST <b>James</b>			MIDDLE <b></b>	LAST <b>Blackwell</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Mattie</b>		MIDDLE <b>L.</b>	LAST <b>Blackwell</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No UNKNOWN</b>			16b. SOCIAL SECURITY NO. <b>577-05-6076-4</b>		17. INFORMANT <b>Wayne Allen</b>		ADDRESS <b>107 Flowing Acres Charles Town, W.Va. 25414</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a), DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIO-RESPIRATORY FAILURE</b>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARDIAC ARRHYTHMIA</b>										
DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARDIAC ARRHYTHMIA</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>DIABETES MELLITUS; OBSTRUCTION, LOWER INTESTINE</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>82</b> , to <b>Dec 17</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>19</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Autor Asuncion</i>			22c. DEGREE <b>MD</b>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN		22e. DATE SIGNED <b>12/30/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Autor C Asuncion</b>			22e. ADDRESS <b>20010 Fishhawk Ave. Poolesville MD 20837</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Dec. 31, 1985</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Riverview Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Wayneboro</b>		COUNTY <b>None</b>	STATE <b>Va.</b>
24. FUNERAL DIRECTOR <b>Wenclay Richardson</b>			25a. ADDRESS <b>P.O. Box 388 Charles Town, W.Va.</b>		25b. DATE REC'D. BY REGISTRAR <b>JAN 2 1986</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

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353138

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME				FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
Hubert Malloy				Dec. 8, 1985				12:50A.M.							
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)							
Male		White		MONTH	DAY	YEAR	IF UNDER 1 YEAR	IF UNDER 24 HRS.							
Feb. 5 1927		58				MONTHS DAYS				HOURS MIN.					
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Penns.		U.S.A.		Montgomery				MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Olney		Montgomery General Hospital				Officer (Retired)				U.S. Air Force					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE					
Maryland		Montgomery		Derwood		8141 Needwood Rd. 20855									
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME									
Joseph				Malloy		Julia				Kelley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Yes		7/50-10/70		200-20-0333				Anne Marie Malloy. Same as item 13.				few hrs.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Irreversible shock															
DUE TO, OR AS A CONSEQUENCE OF (b) Massive hemorrhage of chest " "															
DUE TO, OR AS A CONSEQUENCE OF (c) Ruptured left ventricle of heart " "															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
S/P repair left ventricular aneurysm & coronary bypass.															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
12/8/85		Same				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the physician) attended the deceased from Dec. 7, 1985, to Dec. 8, 1985, that (I) (we) last saw the deceased alive on Dec. 8, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.															
22b. SIGNATURE Michael G. Seremetis, MD. DEGREE															
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DATE SIGNED Dec. 8, 1985															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				3921 Ferrara Dr., Silver Spring, MD									
Michael G. Seremetis															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM				23d. LOCATION							
Burial		12/12/1985		Arlington National Cem.				Arlington, Virginia							
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. NAME ADDRESS 5130 Wisconsin Ave., N.W. Wash., D.C.															
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Julie Seremetis, R.N.															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Form 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be retained for use as the burial/transit permit. Then please remove carbon copy of this certificate and mail it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

INFORMANT: If Item 21 is marked with an "X" know injury or other traumatic event, the individual who witnessed the event should be notified and informed.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 35189

1 -  
FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
<b>LORETTA A MALOV</b>						<b>12/21/85</b>				<b>5:40 PM</b>		
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS	
<b>FEMALE</b>	<b>CAUCASIAN</b>	<b>JAN 9, 1893</b>			<b>92</b>				MONTHS	DAYS	HOURS	MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
<b>PENNSYLVANIA</b>		<b>U.S.A.</b>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<b>MONTGOMERY</b>				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
<b>SILVER SPRING</b>		<b>HOLY CROSS HOSPITAL</b>						<b>HOMEMAKER</b>				
13a STATE		13b COUNTY	13c CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
<b>MARYLAND</b>		<b>MONTGOMERY</b>	<b>SILVER SPRING</b>		YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	<b>700 SLIGO AVENUE 20910</b>					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
<b>CHARLES</b>		<b>A.</b>	<b>BENNIS</b>		<b>ANNA</b>		<b>ELIZABETH</b>			<b>COSTELLO</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
YES		<b>WW I</b>		<b>220-54-1658</b>		<b>CARDIOVASCULAR COLLAPSE</b>			<b>3 HRS.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART II. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASPIRATION OF GASTRIC CONTENTS</b>						<b>3 HRS.</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF (c) <b>INCARCERATED HIATAL HERNIA</b>						<b>48 HRS.</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
					YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
				19 <b>19</b>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>AUGUST 19, 60</b> to <b>DEC 21, 1985</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>DEC 21, 1985</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.												
22b. SIGNATURE <b>James R. Coleman MD</b>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/21/85</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James R. Coleman</b>		22e. ADDRESS <b>9241 COLUMBIA BLVD SILVER SPRING MARYLAND 20910</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <b>12/24/85</b>		23c. NAME OF CEMETERY OR CREMATORIAL GATE OF HEAVEN		23d. LOCATION CITY OR TOWN <b>SILVER SPRING</b>		COUNTY <b>MONTGOMERY</b>		STATE <b>MD.</b>		
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS, JR.</b>		ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 27, 1985</b>		25b. REGISTRAR'S SIGNATURE						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use at the burial/tranport site. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 1b is marked or item 1b shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

360103

1 - FOR STATE REGISTRAR		ITEM NUMBER 4, PER TH. CALL 12-27-85 D.W.		STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.
1. DECEASED NAME (TYPE OR PRINT)		FIRST Robbin		MIDDLE Aaron		LAST Manger		7a. DATE OF DEATH MONTH DAY YEAR		MONTH DAY YEAR		2b. HOUR 3:40 P.M.		
3 SEX <i>m</i>		4. RACE <i>C</i> WHITE		5. DATE OF BIRTH MONTH DAY YEAR 1 30 50		6 AGE (IN YEARS LAST BIRTHDAY) 35 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery								
10. CITY OR TOWN OF DEATH <i>Olney</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Montgomery General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Manger</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Gordon Graphics</i>								
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>MD</i>		13c. CITY OR TOWN <i>Houston</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>3503 ROUTE 97 21738</i>								
14. FATHER'S NAME FIRST <i>Sylvan</i>		MIDDLE <i>A</i>		LAST <i>Manger</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Thelma</i>		MIDDLE		LAST <i>Hoffmann</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>218-46-8332</i>		17. INFORMANT ADDRESS <i>Thelma H Manger, 3503 Rt97 Glenwood Md</i>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>INTRACRANIAL HEMORRHAGE</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) <i>PROGREF EXPANDED BERRY ANEURYSM</i>												
		(c) <i>ATRIAL OR POSTERIOR CEREBRAL</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (1) this hospital attended the deceased from _____ to _____, that (1) (we) lost soul the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did/did not view the body after death.		22b. SIGNATURE <i>Evelyn Jackson</i>		22c. DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>12/18/85</i>				
22d. PHYSICIAN'S NAME <i>Evelyn Jackson, M. D.</i>		22e. ADDRESS <i>5540 Ten Oaks Road Clarksville, MD 21029</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12-20-85</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Mt Olive, Randallstown</i>		23d. LOCATION CITY OR TOWN <i>Randallstown</i>		23e. STATE <i>Baltimore</i>		23f. STATE <i>Md</i>				
24. FUNERAL DIRECTOR NAME <i>Harry H Witzke</i>		ADDRESS <i>4112 Columbia Rd, Ellicott City Md</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 23 1985</i>		25b. REGISTRAR'S SIGNATURE <i>John Mandell</i>								

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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove the signatures. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	5	3	5	1	9
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR			
FELICIA PHOEBE MANGIONE						DECEMBER 31, 1985						10:00P M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 72 HRS			
FEMALE		WHITE		SEPTEMBER 19, 1970 15			YRS			MONTHS	DAYS	HOURS	MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.								
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) student			12b. KIND OF BUSINESS OR INDUSTRY			99999					
13a. STATE NEW YORK		13b. COUNTY		13c. CITY OR TOWN STATEN ISLAND			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 12 Woodland Avenue 10308					
14. FATHER'S NAME FIRST JOHN		MIDDLE R.		15. MOTHER'S MAIDEN NAME FIRST Marie DeSena											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 000-00-000		17. INFORMANT JOHN R. MANGIONE, FATHER			ADDRESS SAME								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF (b) APLASTIC ANEMIA															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from OCTOBER 9, 1985, to DECEMBER 31, 1985, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 31, 1985, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, check here.) <input checked="" type="checkbox"/>										22c. DATE SIGNED 12/31/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE E. BARANSKY		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20892		22f. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 1-2-86		23c. NAME OF CEMETERY OR CREMATORIAL McCallum-Rice Funeral Home			23d. LOCATION CITY OR TOWN Staten Island, N.Y.								
24. FUNERAL DIRECTOR Marshall's Funeral Home 4217 9th St NW Washington, D.C.							25a. DATE REC'D. BY REGISTRAR JAN 8 1986			25b. REGISTRAR'S SIGNATURE Julia Davidson Pendleton					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial permit. Then sign the entire burial permit. Return the burial permit to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 3 5 1 9 2			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR			
Joseph C. Manian						December 26, 1985						7:45a M			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Male			White			MONTH July DAY 25, YEAR 1905			80			MONTHS DAYS		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Harpoot, Armenia			U.S.A.						Montgomery County						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Rockville			Potomac Valley Nursing Home			Engineer			U.S. Gov't.						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
Maryland		Montgomery		Bethesda					7505 Arlington Road / 20814						
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
Giragos			-		Arzoomanian	Martha			-		Gostanian				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS						
No			None			219-42-4277			Peter Manian (Nephew)			West 14th St. #6-D			
New York, New York															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Cardiac Arrhythmia												Acute			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease			
												2 Years			
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
Renal Insufficiency															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE	
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from so the deceased died on <u>12/13</u> 19 <u>85</u> , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did <input checked="" type="checkbox"/> did not view the body after death.			4 19 85			to 12/26 19 85									
22b. SIGNATURE <u>Peter Sherer MD</u>						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Dec/26/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			3947 Ferrara Dr. Wheaton, Md.						
Peter Sherer															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			STATE			
Cremation			JAN. 6, 1986			Chambers Crematory			Riverdale, P.G. Co., Maryland						
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY PROSECUTOR			25b. REGISTRAR'S SIGNATURE						
Chambers Funeral Home			Silver Spring, Maryland			JAN 10 1986									



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

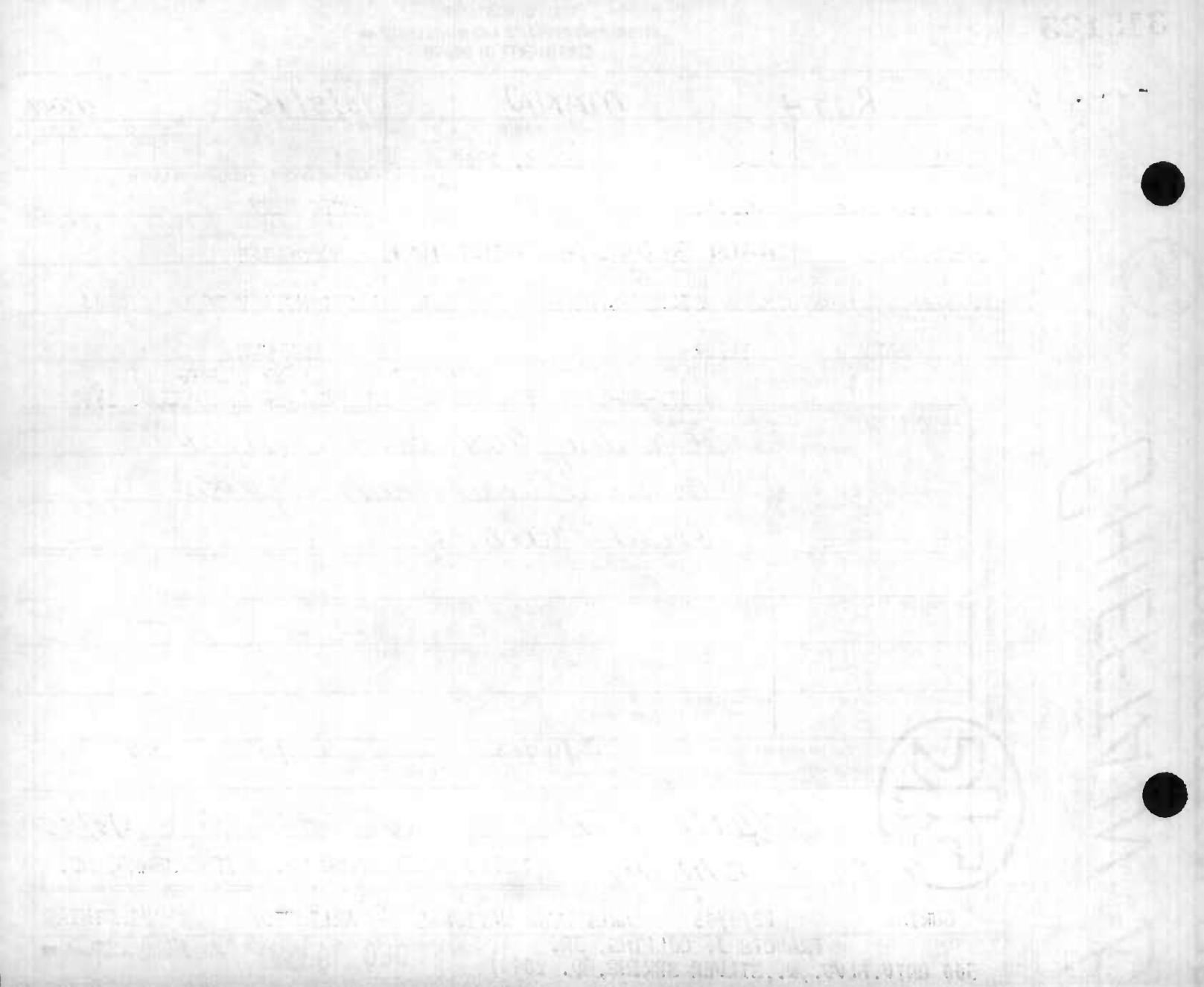
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1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>RUTH</b>	MIDDLE <b>MANN</b>	LAST	2a. DATE OF DEATH MONTH <b>DEC 5 1985</b>	MONTH DAY YEAR	2b. HOUR <b>4:20 PM</b>			
3. SEX			4. RACE		5. DATE OF BIRTH MONTH <b>DEC 9, 1900</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.	7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WEST VIRGINIA</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>					
10. CITY OR TOWN OF DEATH <b>ROCKVILLE</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SHADY GROVE ADVENTIST HOSP</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>SILVER SPRING</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>13801 NOTLEY ROAD 20904</b>					
14. FATHER'S NAME FIRST <b>HENRY</b>			MIDDLE <b>MILLER</b>	LAST	15. MOTHER'S MAIDEN NAME FIRST <b>UNKNOWN</b>	MIDDLE	LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (YES, GIVE WAR OR DATES) <b>577-38-2429</b>		17. INFORMATION DAUGHTER <b>FRANCES MORRIS</b>	ADDRESS <b>627 ELDRID DRIVE SILVER SPRING, MD. 20904</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory and cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive heart failure,瑟斯</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Renal failure</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/4/85</b> , 19_____, to <b>12/5/85</b> , 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED <b>12/5/85</b>	
22b. SIGNATURE <i>Gita Bakshi</i>			22d. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS <b>12105 DARNESTOWN RD., GAITHERSBURG, MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>12/9/85</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>ARLINGTON NATIONAL</b>		23d. LOCATION CITY OR TOWN <b>ARLINGTON</b>		COUNTY	STATE <b>VIRGINIA</b>	
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS, JR.</b>			ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 9 1985</b>		25b. REGISTRAR'S SIGNATURE <i>Francis J. Collins, Jr.</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 shows any injury or other traumatic event, the medical examiner must be notified of same.



352091

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 3 5 1 9 4

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>George D.</i>	MIDDLE <i>Mansell</i>	LAST	2a. DATE OF DEATH MONTH DAY YEAR	MONTH	DAY	YEAR	2b. HOUR 25 7 A.M.	
3. SEX Male		4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Equipment Operator			12b. KIND OF BUSINESS OR INDUSTRY Road Dept.			
13a. STATE Ohio		13b. COUNTY Lake	13c. CITY OR TOWN N. Madison	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1128 Shore Acres Drive / 44057			<i>99977</i>	
14. FATHER'S NAME FIRST Ralph		MIDDLE G.	LAST Mansell	15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE E.	LAST Shimek			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 298-24-9570			17. INFORMANT Mrs. Barbara Mansell, Wife, Same as item #13			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>A acute CardioRespiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma Lung with Metastasis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pneumonia and SHOCKED LUNG syndrome</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Severe Anemia, Leukopenia.</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>12-1-85</i> , 1985, to <i>12-12-85</i> , 1985, that (I) (we) last saw the deceased alive on <i>12-11-85</i> , 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Kamaline V. Deshpande</i>		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>12-12-85</i>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>KAMALINE V. DESHPANDE</i>		22f. ADDRESS <i>6001 Lux Lane Rockville MD 20852</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE December 14, 1985	23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Memorial Parl			23d. LOCATION CITY OR TOWN Rockville			COUNTY	STATE Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. 300 W. Montgomery Ave., Rockville, MD.		25a. DATE REC'D. BY REGISTRAR DEC 16 1985			25b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death. File with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

160820



364066

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM B-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												35195					
												REG. NO.					
1- STATE REGISTRAR			1. DECEASED NAME FIRST CHARLES MIDDLE HENRY LAST MARCHAM									2a. DATE KNOWN TO MONTH DAY YEAR OF ESTI- DEATH MATED Dec. 22, 1985 4400 AM					
5			3. SEX M			4. RACE W			5. DATE OF BIRTH MONTH DAY YEAR March 31 1980		6. AGE (IN YEARS) (LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2b. HOUR 24 HOUR 15 M		
7a. BIRTHPLACE (STATE OR COUNTRY) ENGLAND			7b. CITIZEN OF WHAT COUNTRY? ENGLAND			8. MARRIED WIDOWED XX			NEVER MARRIED DIVORCED		2c. DATE PRONOUNCED DEAD Dec. 22, 1985			2d. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
9. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11738 Victoria Mills Rd									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN			12b. KIND OF BUSINESS OR INDUSTRY BAKERY		
13a. STATE Md			13b. COUNTY Montgomery			13c. CITY OR TOWN Gaithersburg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 11738 Victoria Mills Rd			20902			
14. FATHER'S NAME FIRST UNKNOWN			MIDDLE UNKNOWN			LAST			15. MOTHER'S MAIDEN NAME FIRST UNKNOWN			MIDDLE UNKNOWN			LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. NO			16c. PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cervical atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.			17. INFORMANT SALLY NEWBURY, DAUGHTER, SAME AS ITEM #13			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cervical atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.			(b) <i></i> DUE TO, OR AS A CONSEQUENCE OF			(c) <i></i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																	
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												and in my opinion					
ACTUAL SIGNATURE <i>J. L. Rapp</i>												TITLE (SPECIFY) M.D. <i>Dyer</i> MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS									DATE SIGNATURE <i>Dec. 22, 1985</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/24/85			23c. NAME OF CEMETERY OR CREMATORIAL PARKLAWN CEMETERY			23d. LOCATION CITY OR TOWN ROCKVILLE, MONTGOMERY, MD.			COUNTY			STATE		
24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC. 1804 T ST., N.W., WASHINGTON, D.C. 20009			25a. DATE REC'D. BY REGISTRAR 12/24/85			25b. REGISTRAR'S SIGNATURE <i>John Pendleton</i>											
DHMH - 17 (VR A15 ME (5))																	

330436



354095

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 5 1 9 6

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
ROBERT JOHN MARKS						DECEMBER 12 1985			10:26 a <sup>a</sup>				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE		CAUCASIAN		SEPTEMBER 16 1940		45		YEARS		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MINNESOTA		UNITED STATES								MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BETHESDA		NAVAL HOSPITAL				U.S. NAVY		DEFENSE					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
MINNESOTA		CROW WING		MERRIFIELD				STAR RT. BOX 171		56465			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
ROBERT ROY MARKS						IRIS MARY AMO							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
YES		1957-1985		557-54-7881		BARBARA A. MARKS, STAR RT. BOX 171, MERRIFIELD,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>WIDELY DISSEMINATED LYMPHOMA</u>													
DUE TO, OR AS A CONSEQUENCE OF  (b) _____  DUE TO, OR AS A CONSEQUENCE OF  (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) P.M. 19		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER 17, 1985</u> to <u>DECEMBER 12, 1985</u> , that (I) (we) last saw the deceased alive on <u>DECEMBER 12, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Bru ( 716</i>		DEGREE <i>MO</i>		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>1308C 85</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. L. FLAX, LT MC USNR</i>		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814											
23a. BURIAL, CREMATION, REMOVAL CREMATION		23b. DATE DEC. 14, 1985		23c. NAME OF CEMETERY OR CREMATORIAL LEE'S CREMATOR		23d. LOCATION CITY OR TOWN WASHINGTON, D. C.		COUNTY		STATE			
24. FUNERAL DIRECTOR MARSHALL'S FUNERAL HOME, 4217 ADDRESS WASH., D.C. 20011						25a. DATE REC'D. BY REGISTRAR DEC 19 1985		25b. REGISTRAR'S SIGNATURE <i>J. L. K. [Signature]</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be retained for use as the burial/transit permit. Then please remove from this certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other significant event, the medical examiner must be notified at once.



014062

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 35191

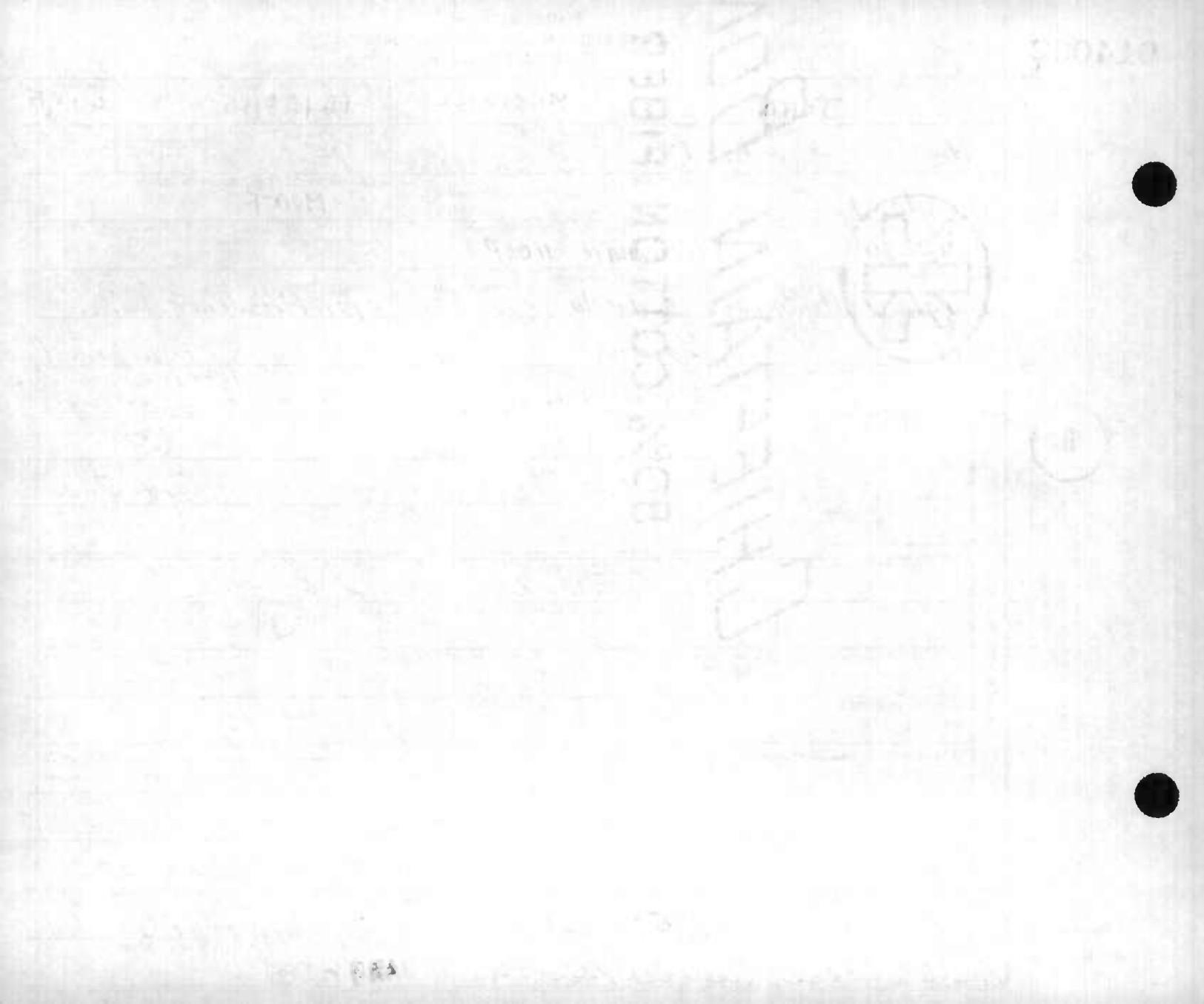
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST JOHN	MIDDLE	LAST MARSHALL	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
3 SEX			4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)				4:05 AM			
Male			Black	5 2 1890	95				IF UNDER 1 YEAR	IF UNDER 24 HRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?	8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH			MONTHS	DAYS	HOURS	MIN.
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
BETHESDA			SUBURBAN HOSP			-			MD.			
13a STATE			13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE			24843			
Maryland			Montgomery	Bethesda		5721 Grosvenor Lane						
14 FATHER'S NAME			FIRST Ed	MIDDLE	LAST Marshall	FIRST Ana	MIDDLE	LAST Marshall				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS 11301 North Keys			
No			579-10-9164A			Wendell Lee Rd, Brandywine, Md. 20613						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			Septicemia			APPROXIMATE INTERVAL IN MONTHS			
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) Septicemia						6 months			
DUE TO, OR AS A CONSEQUENCE OF (c) Septicemia												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20c IF YES, NATURE OF INJURY IN TERM 10 OF PART 2			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22 I certify that (I) (this hospital) attended the deceased from 12/27/85 to 12/28/85, that (I) (we) last saw the deceased alive on 12/27/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
23a SIGNATURE THOMAS G. WARD			23b DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 12/28/85			
23d BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23e NAME OF CEMETERY OR CREMATORIAL ST. THOMAS CH. CEM.			23f LOCATION CITY OR TOWN BRANDYWINE P.G. MD			23g DATE REC'D. BY REGISTRAR JAN 5 1986			
24 FUNERAL DIRECTOR NAME Maurice Adens			ADDRESS American Md. 20608			23h REGISTRAR'S SIGNATURE						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other trauma, report the medical examiner immediately.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office within 72 hours after death. Then please remove carbon paper. Please I would like to have this form filled out before I sign it.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

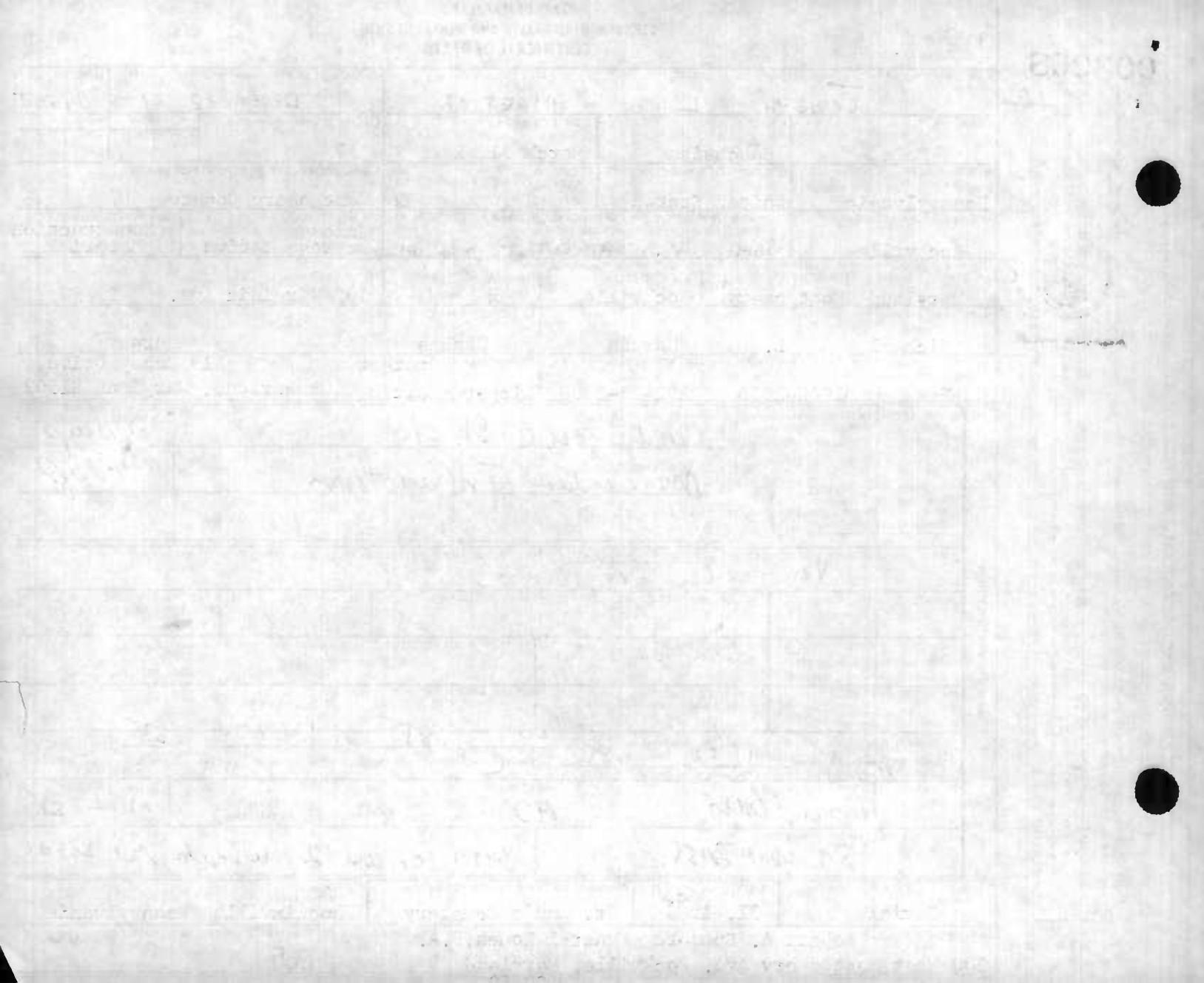
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

5 3 35 198

003068

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>JOSEPH</i>	MIDDLE <i>L</i>	LAST <i>MARTIN</i>	2a. DATE OF DEATH MONTH YEAR	DAY	YEAR	2b. HOUR DEC 27 85 0955AM		
3. SEX  Male			4. RACE  Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 31, 1928	6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  Pennsylvania			7b. CITIZEN OF WHAT COUNTRY?  United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH  Montgomery County, MD					
10. CITY OR TOWN OF DEATH  Rockville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  SHAD GROVE ADVENTIST HOSPITAL		12a. USUAL OCCUPATION  Sales Representative		12b. KIND OF BUSINESS OR INDUSTRY  Construction Material				
13a. STATE  Maryland			13b. COUNTY  Montgomery	13c. CITY OR TOWN  Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS  102 Virginia Ave. 20850					
14. FATHER'S NAME FIRST  Michael			MIDDLE  L.	LAST  Martin	15. MOTHER'S MAIDEN NAME FIRST  Daphne	MIDDLE  Murphy	LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1946-1948		17. INFORMANT Brother	ADDRESS 519 Cobey Drive Cumberland, Maryland 21502					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cardiogenic Shock		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DOUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction		4 days						
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):  Ventricular Arrhythmia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED AT WHILE WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (1) (this hospital) attended the deceased from saw the deceased alive on 11/27 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) we did (did not) view the body after death.		11/20 1985		11/27 1985		11/27 1985		11/27 1985		11/27 1985	
22b. SIGNATURE  <i>Raymond Bass</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-27-85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)  RAYMOND BASS		22e. ADDRESS  3929 Ferrara & Wheaton Rd 20801									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 31, 1985		23c. NAME OF CEMETERY OR CREMATORIAL St. Ann's Cemetery		23d. LOCATION CITY OR TOWN Phoenixville		COUNTY	STATE Pennsylvania		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. 300 West Montgomery Ave., Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 31 1985		25b. REGISTRAR'S SIGNATURE <i>Julia Dawson Hendell</i>					



358056

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 5 1 9 7

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME      FIRST      MIDDLE      LAST				2a. DATE OF DEATH      MONTH      DAY      YEAR				2b. HOUR													
Huell L. Mateer				December 17, 1985				3:20AM M													
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR													
Male		Caucasian		Month Sept. Day 13, Year 1907		78		IF UNDER 1 YEAR MONTHS    DAYS													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH													
North Carolina		United States				Montgomery County, MD.		Silver Spring													
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY		13c. CITY OR TOWN											
Chevy Chase Nursing Home		Auto Mechanic		U.S. Navy		Maryland		Montgomery		Rockville											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		19. DATE OF OPERATION		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
Jasper Lee Mateer		Maggie		no		577 09 1835		Nora R. Mateer, see # 13		Cause of Death Carrying gun caused by hemisphere disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. YES <input type="checkbox"/> NO <input type="checkbox"/>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) due to, or as a consequence of		(c) due to, or as a consequence of		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e. LOCATION STREET		21f. CITY OR TOWN		21g. COUNTY		21h. STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>Sep 11</u> 1985 to <u>Dec 11</u> 1985, that (I) (we) last saw the deceased alive on <u>Sep 11</u> 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death		22b. SIGNATURE <u>William H. Killay</u>		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS 8218 Wisconsin Ave. Bethesda, Md.		22f. DATE SIGNED Dec. 17, 1985		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 20, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Memorial Park		23d. LOCATION Rockville		23e. COUNTY Maryland	
24. FUNERAL DIRECTOR NAME <u>ROBERT A. PUMPHREY FUNERAL HOMES</u> ADDRESS <u>PA. 300 West Montg. Ave. Rockville, Maryland</u>		DATE REC'D. BY REGISTRAR <u>DEC 20 1985</u>		25b. REGISTRAR'S SIGNATURE <u>John W. Pendleton</u>																	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

61166



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours of the time of death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in my funeral director. Then please remove carbon paper. Pages 1 and 2 should be detached for use on the Burial/Transit permit. Then please remove carbon paper. Pages 1 and 2 should be detached for use on the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT) If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified before

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 8535200									
1. FOR STATE REGISTRAR <b>003075</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>12/27/85</b>			2b. HOUR <b>4:55 PM</b>										
1. DECEASED NAME (TYPE OR PRINT) <b>Vanese Barker Mathews</b>		MIDDLE <b>Barker Mathews</b>		3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 4, 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70 YRS.</b>		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Utah</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>									
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>		12a. USUAL OCCUPATION <b>Phonales- Classified Post</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Washington Post</b>									
13a. STATE <b>N/A</b>		13b. COUNTY <b>N/A</b>		13c. CITY OR TOWN <b>Washington D.C.</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		14. STREET ADDRESS / ZIP CODE <b>403 Quackenbos Street, N.E. 29999</b>							
15. FATHER'S NAME FIRST <b>Frederick</b>		MIDDLE <b>Barker</b>		LAST <b>Barker</b>		16. MOTHER'S MAIDEN NAME FIRST <b>Della</b>		MIDDLE <b>Ann</b>		LAST <b>Hickenlooper</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>528-09-5175</b>		17. INFORMANT <b>Thomas A. Mathews (Husband)</b>		ADDRESS <b>Same as #13</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<b>intra-abdominal carcinoma of colon</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>m.</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		<b>cancer of colon</b>										<b>m.</b>			
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING □ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d. INJURY OCCURRED WHILE WORKING □ NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 27</b> , 19 <b>85</b> , to <b>Dec 27</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <b>Martin O. Melton</b>		DEGREE		ATTENDING PHYSICIAN <b>Martin O. Melton</b>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/27/85</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WEIZ Martin O. Melton</b>		22e. ADDRESS <b>1525 Greenway Ct. Anne Arundel</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/31/85</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Fort Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Brentwood</b>		23e. STATE <b>P.G. Maryland</b>							
24. FUNERAL DIRECTOR NAME <b>Frank's Gasch's Sons Funeral Home, P.A.</b>		ADDRESS <b>4739 Baltimore Avenue, Hyattsville, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 31 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Lia Davidson-Randall</b>									



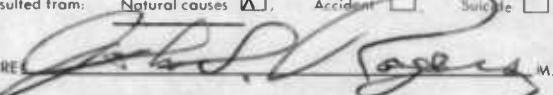
353030

#16, per F.H. 12/27/85 kam

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 35201

1- STATE REGISTRAR

DECEASED NAME (TYPE OR PRINT)			FIRST John	MIDDLE Rhodes	LAST Matteson	2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> MONTH 12/16 DAY 19 YEAR 85 2:41 A.M.	2b. HOUR 2:41	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH Jun. 26, 1932	YEAR 53	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 53	IF UNDER 1 YR. <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	7c. DATE PRONOUNCED DEAD 12/16 1985 A.M.	2c. HOUR 2:41	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cornwall New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT A SUCH FACILITY, GIVE STREET ADDRESS) 2301 Hidden Valley Lane			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Consultant		12b. KIND OF BUSINESS OR INDUSTRY US Govt.	
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2301 Hidden Valley Lane	13f. ADDRESS Silver Spring 20904		
14. FATHER'S NAME Richard		15. MOTHER'S MAIDEN NAME Louis Matteson Marjorie Stewart Mapes		17. INFORMANT Joan E. Matteson 2301 Hidden Valley Lane				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Vietnam 081-32-5173		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) Carcinoma of the colon. DUE TO, OR AS A CONSEQUENCE OF  { Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.  (b) DUE TO, OR AS A CONSEQUENCE OF  (c)				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1½ years								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) None								
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE 								
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.								
23a. BURIAL, CREMATION, REMOVAL Cremation		23b. DATE 12/17/85		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore Washington Crematory		23d. LOCATION CITY OR TOWN Laurel Prince Geo Md.		
24. FUNERAL DIRECTOR Donald V. Borgwardt		ADDRESS 4400 Powder Mill Rd Beltsville Md 20705		25a. DATE REC'D. BY REGISTRAR DEC 17 1985		REG. TRANS SIGNATURE 		
DHMH - 17 (VR A15 ME (5))								

OC Hesd.

John Hesd.

357052

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1 AND 2 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 ARE TO BE FILLED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 35202					
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			1- MAUNG			2a. DATE KNOWN OF ESTI. DEATH MATED					
			TUE						MAUNG			AD MONTH DAY YEAR					
3 SEX			4 RACE			5 DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN			2b. DATE PRONOUNCED DEAD		
M INDONESIAN			MARCH 15, 1915			70 yrs.			8. MARRIED WIDOWED			Dec 12, 1985			1985		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED NEVER MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NO SUCH FACILITY, GIVE STREET ADDRESS)		
BURMA			BURMA									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			20906		
MD			Montgomery			MD						4413 Conger St.					
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			DAW SEIN NYUNT					
U PE						KHIN			DAW								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ACUTE MYOCARDIAL DIS.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO			067-68-4831			DAW HLA MYINT (SAME AS #13)											
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.			DUE TO, OR AS A CONSEQUENCE OF						(b)			CHRONIC MYOCARDIAL DIS.					
			DUE TO, OR AS A CONSEQUENCE OF						(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
None			19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>														
ACTUAL SIGNATURE <i>John S. Rogers</i>			TITLE (SPECIFY) MEDICAL EXAMINER												DATE SIGNED 12/19/85		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			1919 SEMINARY Rd. S.S. Md.											
23a. BURIAL, Cremation, Removal (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE		
CREMATION			DEC. 13, 1985			CHAMBERS CREM.			RIVERDALE P.G.C. Md.								
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
W. W. CHAMBERS			Co. Inc. SILVER SPRING MD.			DEC 19 1985											

SE 01/05

REGAL COTTON & CLOTHES



361056

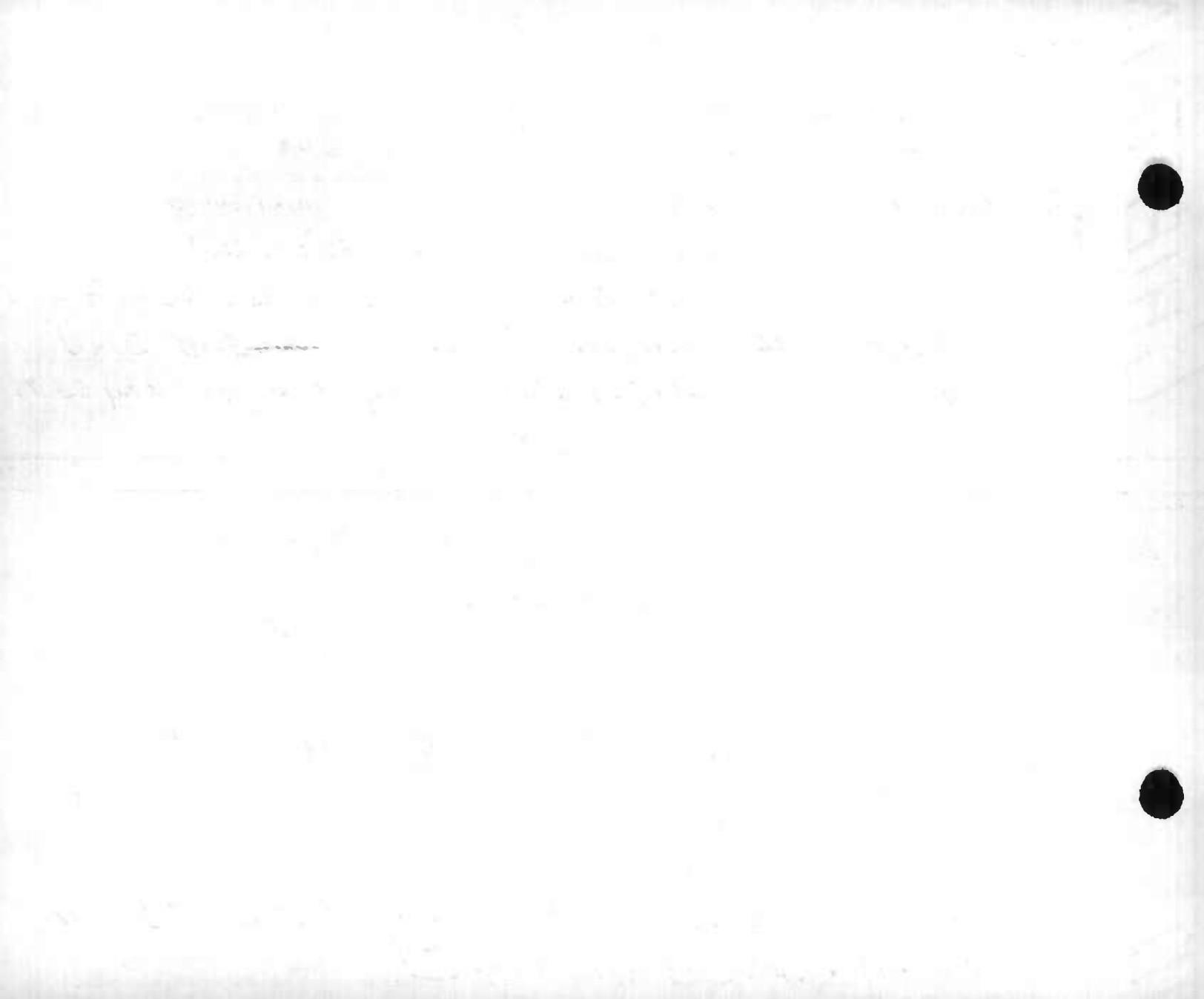
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 3 should be carbon-preserved. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE						85	35203					
CERTIFICATE OF DEATH						REG. NO.						
1. DECEASED NAME			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			June	H.	May	12/22/1985				1512 M		
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
F		WHITE	MONTH	DAY	YEAR	66		MONTHS	DAYS	HOURS	MIN.	
6. AGE (IN YEARS LAST BIRTHDAY) YRS.												
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
MICHIGAN			U.S.A.					MONTGOMERY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
TAKIEN PARIS			WASHINGTON ADVENTIST HOSPITAL			EDITOR (RET.)						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>						
13c. STATE		13d. COUNTY		13e. CITY OR TOWN		13e. STREET ADDRESS / ZIP CODE						
MD.		MONT		SILVER SPRING		3906 BEL PRE Rd. #4-20902						
14. FATHER'S NAME			FIRST	MIDDLE	LAST	FIRST	MIDDLE	15. MOTHER'S MAIDEN NAME				
ROBERT			LEE		AYDON	JLA	GLODYS	DONN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS				
No			216 07 5820			JERRY C. MAY, 13104 SERPENTINE Key S.S.#						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						Due to, or as a consequence of (b) <i>failure in liver</i>						
						Due to, or as a consequence of (c) <i>metastatic small cell lung cancer</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
21d. INJURY OCCURRED  WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) this hospital attended the deceased from <i>12/21/1985</i> to <i>12/22/1985</i> , that (I) we last saw the deceased alive on <i>12/21/1985</i> and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we (did) (did not) view the body after death.												
22b. SIGNATURE <i>DR. HAIDAK</i>						DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>12/23/85</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DR. HAIDAK</i>						22e. ADDRESS <i>Clinton Md</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <i>Dec. 27, 1985</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Tall Larch Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Brentwood</i>			
24. FUNERAL DIRECTOR NAME <i>Takien Paris Home of Resting, 219 Carroll Street DC</i>						25a. DATE REC'D. BY REGISTRAR <i>Dec 24 1985</i>			25b. REGISTRAR'S SIGNATURE <i>www.baldwin-maryland.com</i>			



008001

214  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

85 35204

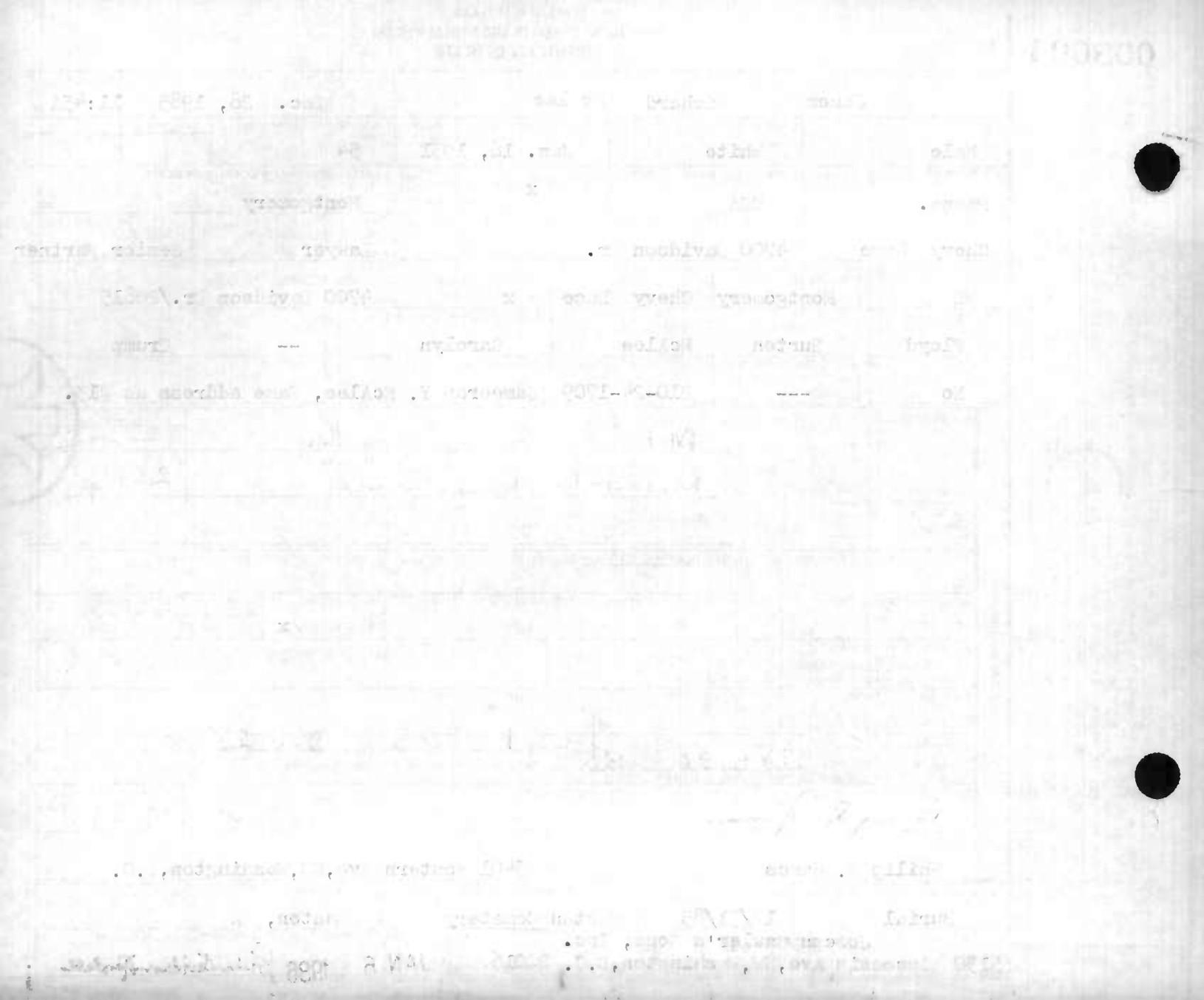
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then place the original in the papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other final disposition. In event, the medical examiner must be notified at once.

IMPORTANT: If item 21 is marked as Item 18 shows any injury, or other cause contributing to death, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
James Richard McAlee						Dec. 28, 1985				11:45A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		MONTH DAY YEAR Jan. 16, 1951		54		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
Penns.		USA									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Chevy Chase		4700 Davidson Dr.		Lawyer		Senior Partner					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13e. STREET ADDRESS / ZIP CODE 4700 Davidson Dr./20815					
14. FATHER'S NAME FIRST Floyd			MIDDLE Burton			LAST McAlee			15. MOTHER'S MAIDEN NAME FIRST Carolyn		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. No			17. INFORMANT ADDRESS			LAST Trump		
			210-24-1709			Sameeran Y. McAlee, Same address as #13.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks					
Metabolic Encephalopathy											
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic lung Cancer						2Y 2 yr					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (we) attended the deceased from <u>July 1, 1985</u> , to <u>Dec 28, 1985</u> , that (I) (we) last saw the deceased alive on <u>Dec 26, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Philip R. James</u>		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Philip R. James		22e. ADDRESS 5401 Western Ave, NW, Washington, D.C.				22f. DATE SIGNED 12-29-85					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/31/85		23c. NAME OF CEMETERY OR CREMATORIAL Easton Cemetery		23d. LOCATION CITY OR TOWN Easton, PA		COUNTY		STATE	
24 FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C. 20016						25a. DATE REC'D. BY REGISTRAR JAN 6 1986		25b. REGISTRAR'S SIGNATURE <u>Greta Davidson-Purcell</u>			

110230



365259

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

35205

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>JUNELLE J. MCBRIDE</i>						DECEMBER 20, 1985				5:15P M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
FEMALE		WHITE		DECEMBER 6, 1934		51					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Tennessee		United States				Montgomery County, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BETHESDA		NIH, THE CLINICAL CENTER		Homemaker		Own Home					
13a. STATE MARYLAND		13b. COUNTY Anne Arundel		13c. CITY OR TOWN GLEN BURNIE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7962 Crownsway		21061	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
William		Brady		Johnson		Ruby				Fulghum	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT (Husband) ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PNEUMONIA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		408-66-3761		MR. VICTOR MCBRIDE		SAME AS item #13		2 Weeks			
19. MEDICAL CERTIFICATION		20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>JUNE 25</u> , 19 <u>85</u> , to <u>DECEMBER 20</u> , 19 <u>85</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>DECEMBER 20</u> , 19 <u>85</u> , and that in <input type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.											
22b. SIGNATURE <i>Joyce A. O'Shaughnessy, MD</i>		22c. DATE SIGNED <u>12/22/85</u>		22d. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD 20892					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE December 24, 1985		23c. NAME OF CEMETERY OR CREMATORIAL <i>Oak Hill Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Selmer</i>		CITY OR TOWN <i>Tennessee</i>			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., 7557 Wisconsin Ave., Bethesda, Maryland		25. DATED REC'D. BY REGISTRAR <u>DEC 27 1985</u>		25b. REGISTRAR'S SIGNATURE <i>J. McBride</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Please file within 72 hours of the death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

en



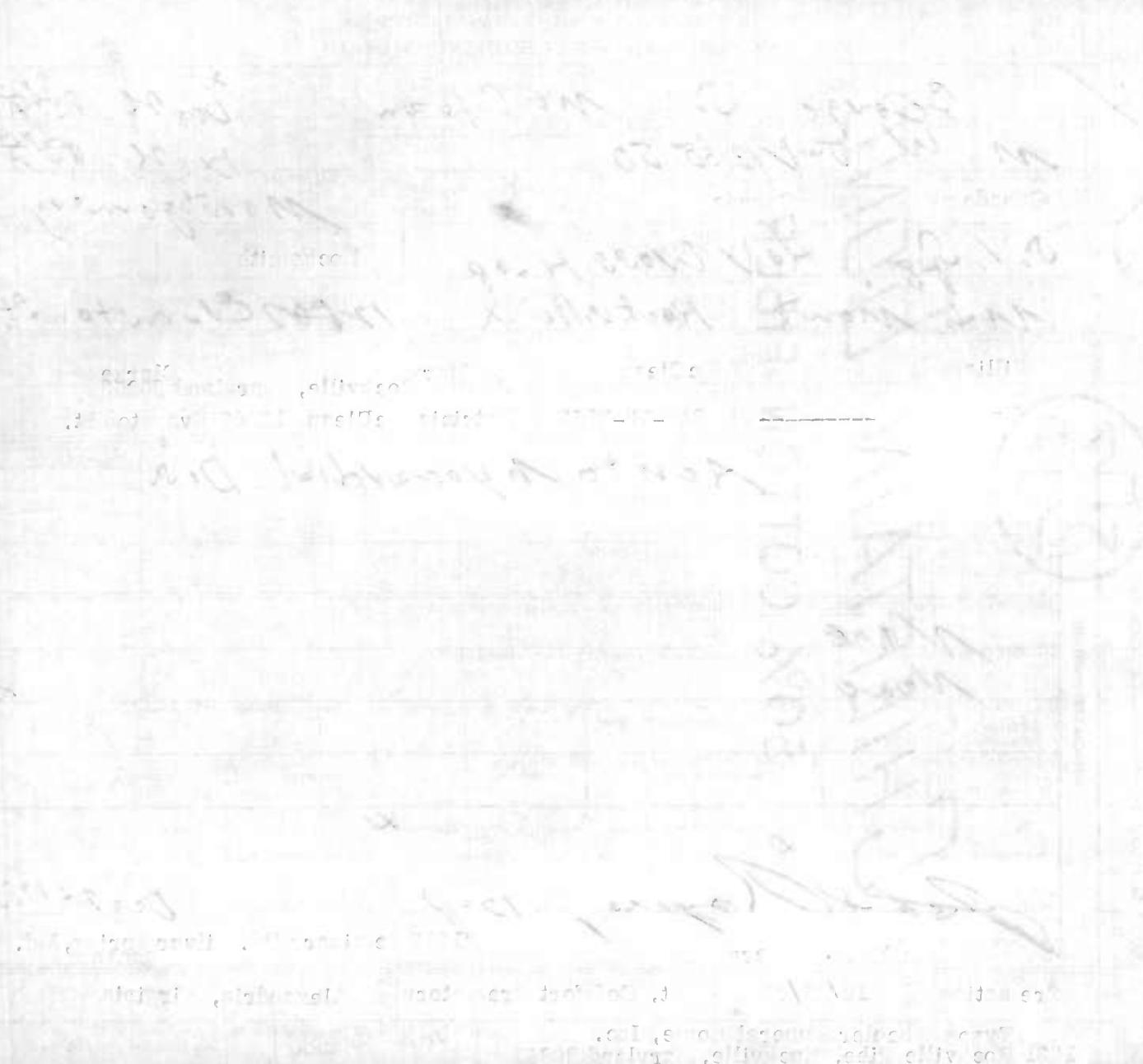
007081

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR, EXECUTE THE CERTIFICATE. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3 RETAIN PAGE 3 FOR A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												35200				
												REG. NO.				
1- FOR STATE REGISTRAR			FIRSt			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
RELEASED NAME (TYPE OR PRINT)			<i>George S. McClean</i>									<input checked="" type="checkbox"/>	Dec 26	19	AM	0745
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
<input checked="" type="checkbox"/> M		<input checked="" type="checkbox"/> W		<i>July 13 1935</i>		50 yrs.						<input checked="" type="checkbox"/>	Dec 26	19	AM	0745
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			<i>Montgomery MD</i>				
Canada			Canada													
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN HOSPITAL HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
<i>D.C. Spa</i>			<i>Holy Cross Hosp</i>			<i>Locksmith</i>										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		12807 Evanston St.						
<i>MD</i>		<i>Montgomery</i>		<i>Rockville</i>		YES <input checked="" type="checkbox"/>		<i>12807 Evanston St.</i>								
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				
<i>William</i>						<i>McClean</i>			<i>Mary</i>			16b. SOCIAL SECURITY NO. <i>214-70-2053</i>				
												17. INFORMANT <i>Patricia McClean 12807 Evanston St.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anterior myocardial Dis.</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>None</i>																
19a. DATE OF OPERATION <i>None</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>John S. Rogers</i> TITLE (SPECIFY) M.D. <i>12 ap</i>												Inquiry <input type="checkbox"/> and in my opinion				
EXAMINER'S NAME (TYPE OR PRINT)			John S. Rogers			ADDRESS			MEDICAL EXAMINER			DATE SIGNED <i>Dec 26 1985</i>				
23a. BURIAL, CREMATION, REMOVAL <i>Cremation</i>			23b. DATE <i>12/28/85</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Comfort Crematory</i>			23d. LOCATION CITY OR TOWN			24. FUNERAL DIRECTOR NAME <i>Tyson Wheeler Funeral Home, Inc.</i> ADDRESS <i>1331 Rockville Pike, Rockville, Maryland 20852</i>				
												25a. DATE REC'D BY REGISTRAR <i>JAN 3 1986</i>			25b. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>	

100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be used within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified or called.

007121

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 3535207

FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

OLLIE

MARIE

McCORMICK

DEC. 30, 1985

5:45AM

3. SEX

FEMALE

4. RACE

WHITE

5. DATE OF BIRTH

MONTH APR. DAY 23, YEAR 1916

6. AGE (IN YEARS LAST BIRTHDAY)

69

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

GEORGIA

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8

MARRIED  NEVER MARRIED   
WIDOWED  DIVORCED 

9. BALTIMORE CITY OR COUNTY OF DEATH

MONTGOMERY CO.

MD.

10. CITY OR TOWN OF DEATH

KENSINGTON

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

11011 DRUMM AVE.

12a. USUAL OCCUPATION  
(TYPE OF WORK FOR MOST OF WORKING LIFE)

COOK

12b. KIND OF BUSINESS OR INDUSTRY

RESTAURANT

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE  
Md.13b. COUNTY  
MONTGOMERY13c. CITY OR TOWN  
KENSINGTON13d. INSIDE CITY LIMITS?  
YES  NO 13e. STREET ADDRESS / ZIP CODE  
11011 DRUMM AVE. 20895

14. FATHER'S NAME

BENNIE

MIDDLE  
R.LAST  
ROBINSON

15. MOTHER'S MAIDEN NAME

FIRST  
MARYMIDDLE  
MOLLYLAST  
PRICKETT16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

NO

16b. SOCIAL SECURITY NO.  
256-28-8223

17. INFORMANT

BOBBY G. McCORMICK

(SAME AS ITEM #13)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

- Respiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Retinitis Prostomatitis Adenovaginitis

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c) Endometrial Carcinoma

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES NO YES NO 21a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED

WHILE  NOT WHILE   
AT WORK  AT WORK 21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET

CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from  
saw the deceased alive on 26 Dec 55, and that in (my) opinion death occurred on the date and hour and from the causes stated  
above, (I) did (did not) view the body after death.

22b. SIGNATURE

22c. PHYSICIAN'S NAME (TYPE OR PRINT)

JOHN KUHN

DEGREE

ATTENDING PHYSICIAN  MEDICAL DIRECTOR  STAFF PHYSICIAN 

22c. DATE SIGNED

DEC. 30, 1985

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)23b. DATE  
1-3-198623c. NAME OF CEMETERY OR CREMATORIUM  
ROSE HILL CEMETERY23d. LOCATION  
CITY OR TOWNCOUNTY STATE  
ALMA BACON CO. GA.

24. FUNERAL DIRECTOR

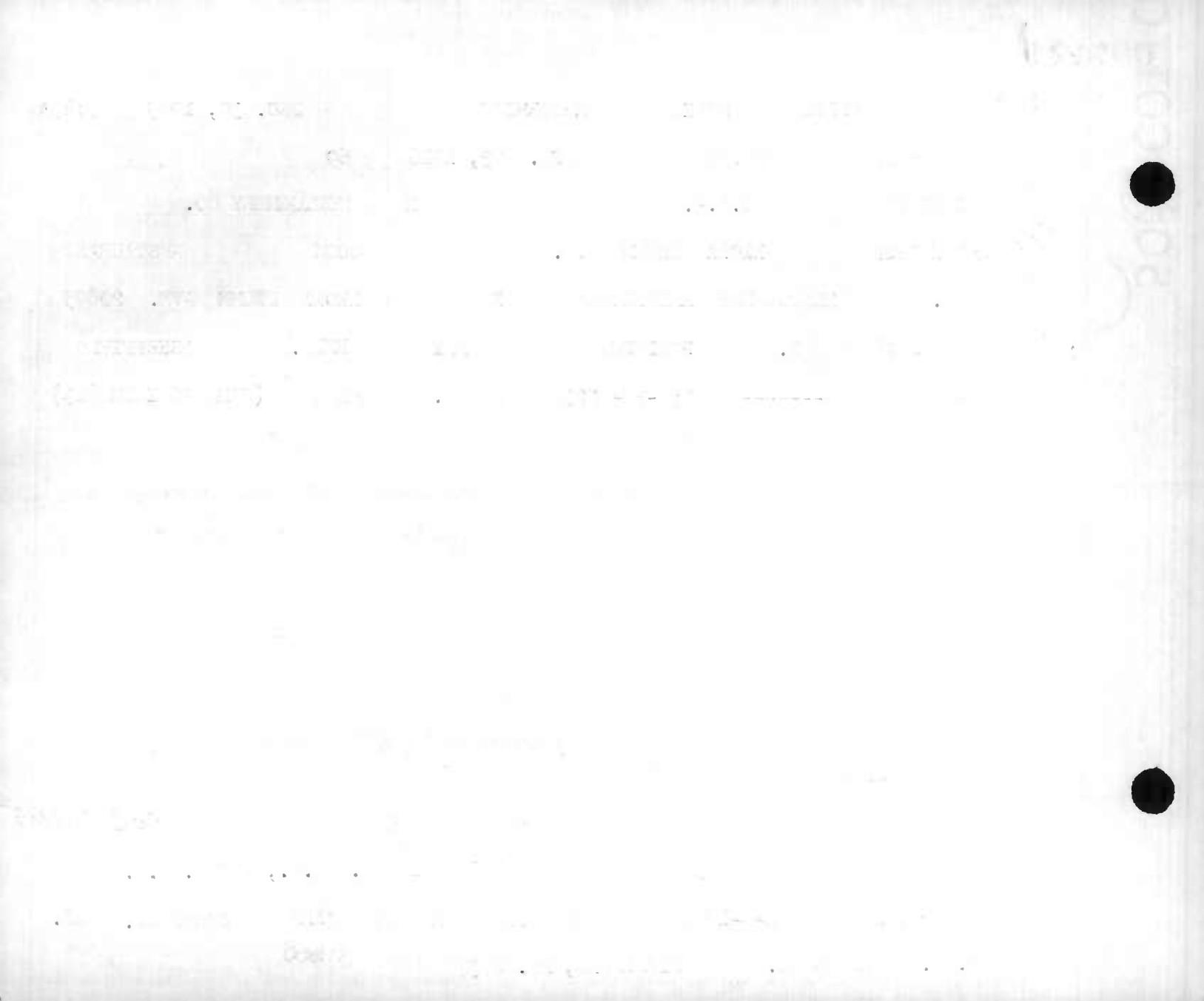
NAME  
W. W. CHAMBERS CO.ADDRESS  
RIVERDALE, MD. 20737

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

JAN 3 1986

jane warden-hendell



364071

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 5 2 0 8

REG. NO.

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Robert W. McDIFFETT						Dec. 23, 1985				11:20 A.M.	
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
<input checked="" type="checkbox"/> Male		White	March 8, 1919			66 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania		American				Montgomery County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Rockville		Shady Grove Adventist Hosp.			Bookkeeper			Hotel			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE	20879			
Maryland		Montgomery	Gaithersburg				23301 Woodfield Road				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST			
		Frank	E.	McDiffett	Alta			Hirleman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
Yes		191-07-5781			Rosemary S. McDiffett Item 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cystic fibrosis, hypertension cardio 10 years</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Asperger disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
					<input type="checkbox"/> NO <input checked="" type="checkbox"/>			<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED  WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>12/16/85</u> , to <u>12/23/85</u> , 19 <u>85</u> , that (1) (he) last saw the deceased alive on <u>12/13/85</u> , 19 <u>85</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (1) (he) did <input checked="" type="checkbox"/> view the body after death.											
22b. SIGNATURE <u>James P. Kerr, M.D.</u>					DEGREE			22c. DATE SIGNED			
24a. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED			
James P. Kerr, M.D.		26618 Ridge Rd., Damascus, Md.						Dec. 23, 1985			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		COUNTY	STATE	
Burial		12/26/85		Sylvan Heights			Uniontown		Pennsylvania		
24 FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Olin L. Molesworth, P.A., Damascus, Md.					DEC 26 1985						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and page 2 should be mailed to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked, see Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



365137

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 10 FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												35207	
												REG. NO.	
1- STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			LAST			2a DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR	
			William James McGee						<input checked="" type="checkbox"/> 12-20 1985			0300AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD	
Male		White		3 4 35		50 yrs.						12-20 1985	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8.		9. BALTIMORE CITY OR COUNTY OF DEATH							
New Hampshire		U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						Montgomery	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
Rockville			Shady Grove Adventist Hospital			Retired Military			U.S. Army				
13a STATE Maryland			13b COUNTY Montgomery			13c CITY OR TOWN Gaithersburg			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1112 Westside Drive 20878	
14. FATHER'S NAME FIRST Edward			MIDDLE			LAST McGee			15. MOTHER'S MAIDEN NAME FIRST Marjorie			LAST Perkins	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. Viet Nam			17. INFORMANT Wan K. McGee same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
{ (b) <i>Coronary artery Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?							
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN				
									COUNTY			STATE	
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>John Gamber</i>			TITLE (SPECIFY) M.D. <i>Douglas</i>			MEDICAL EXAMINER <i>Bethesda Md.</i>			DATE SIGNED <i>12-21-85</i>				
EXAMINER'S NAME (TYPE OR PRINT) <i>John Gamber</i>			ADDRESS <i>8218 Wisconsin Ave</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/24/85			23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cemetery			23d. LOCATION CITY OR TOWN Arlington, Virginia			STATE	
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852						25a. DATE REC'D. BY REGISTRAR DEC 27 1985			25b. REGISTRAR'S SIGNATURE <i>Jane Davidson Pendell</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please return this form to the State Dept. of Health and Mental Hygiene prior to burial, creating all necessary documents.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury or other trauma, record all such injuries.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												35210				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)				FIRST <i>Anne</i>	MIDDLE <i>R.</i>	LAST <i>McGinness</i>	2a. DATE OF DEATH MONTH YEAR				DAY	YEAR	2b. HOUR AM. / PM.			
3. SEX <b>Female</b>				4. RACE <b>White</b>			5. DATE OF BIRTH MONTH <i>October</i>				DAY <i>20</i>	YEAR <i>02</i>	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fernwood House</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>				
13a. STATE <b>Md.</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4618 DeRussey Pkwy.</b>		ZIP CODE <b>20815</b>				
14. FATHER'S NAME FIRST <b>George</b>				MIDDLE <b>F.</b>	LAST <b>Topper</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Maude</b>				MIDDLE <b>T</b>	LAST <b>Crum</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO) <b>No</b>				16b. SOCIAL SECURITY NO. <b>214-36-2073</b>				17. INFORMANT <b>John J. McGinness. Same as item 13.</b>				ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for each cause) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.												APPROPRIATE INTERVAL BETWEEN DEATH AND DEATH <b>1 044</b>				
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Respiratory Failure</i> <i>Chronic obstructive pulmonary disease</i> 20 yrs.																
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic heart disease - Parkinson's Dis.</i>																
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) <i>1978</i>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>1978</i> , 19_____, to <i>12/11/85</i> , 19_____, that (I) (we) last saw the deceased alive on <i>12/8/85</i> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																
22b. SIGNATURE <i>Henry C. Scovigg Jr.</i>												DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>13/11/85</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Henry C. Scovigg Jr.</b>				22e. ADDRESS <b>5413 Cedar Lane Bethesda Md</b>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>12/14/1985</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Gate of Heaven Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Silver Spring, Md.</b>								
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons Inc.</b> ADDRESS <b>5130 Wisconsin Ave., N.W. Wash., D.C.</b>												25a. DATE REC'D. BY REGISTRAR <b>DEC 16 1985</b>				
												25b. REGISTRAR'S SIGNATURE <i>John J. McGinness</i>				



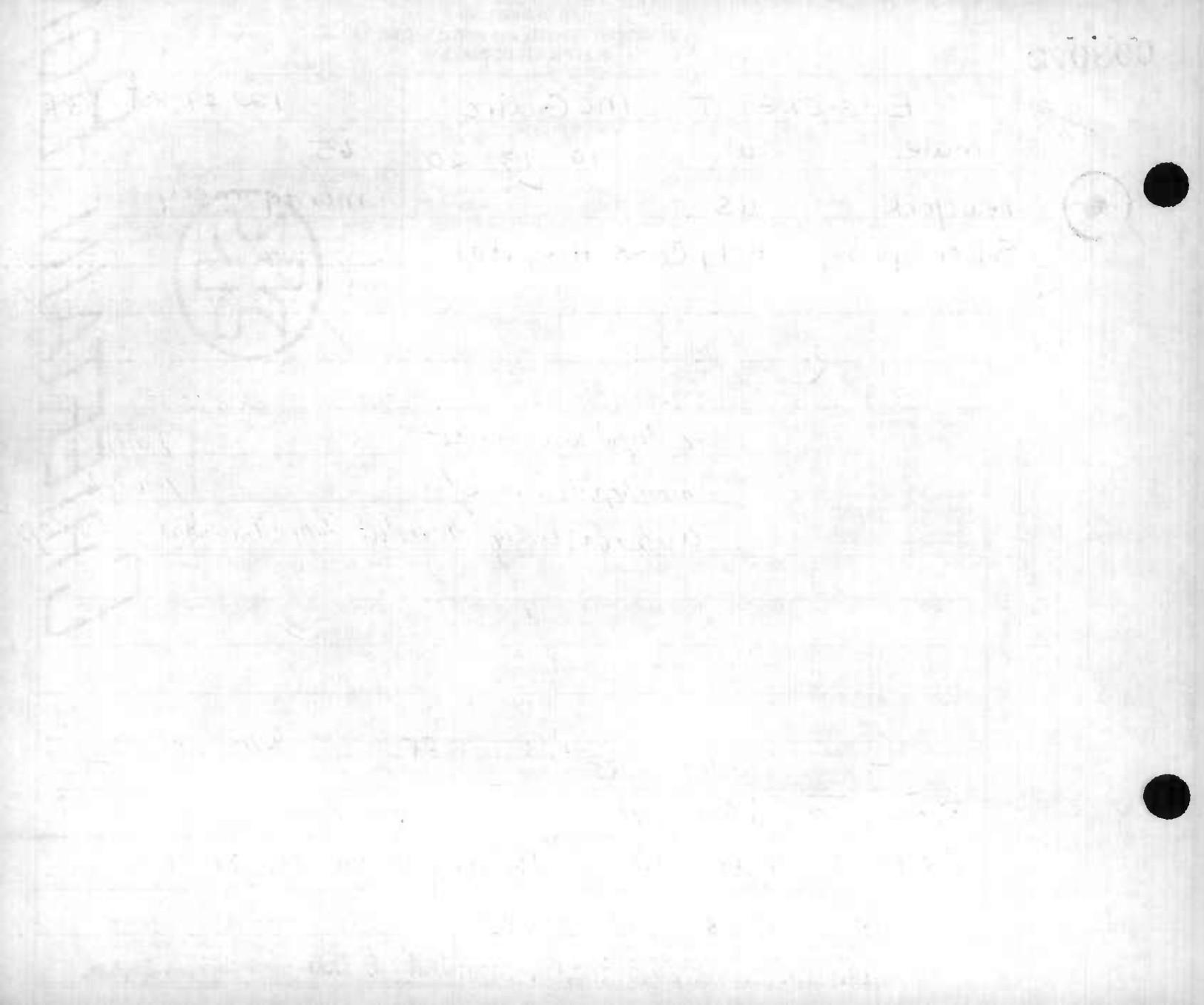
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Funeral Record 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "18 shows any injury, or other traumatic event," the medical certification section must be completed or struck through.

008072

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 3 5 2 ! !			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
EUGENE T mcGuire						12 29 85						6:30 P.M.			
3. SEX		4 RACE		5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
male		W		MONTH DAY YEAR			65			MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.				
new York		USA			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			montgomery							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital										ACCOUNTANT		L.I.S.B.E.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE					
MARYLAND		MONTGOMERY		SILVER SPRING			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			3319 KILKENNY STREET 20904					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
DAVID		J.		mcGUIRE	MARY					TIERNAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
YES		WW II			135-14-7503			ESTHER M. mcGUIRE			SAME AS 13			WIFE	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 minute			
DUE TO, OR AS A CONSEQUENCE OF (b) bronchopneumonia												1 week			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) cerebral vascular accident (brainstem infarct)												26 days			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
		P.M. 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 12/27 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												19 85 to 12/27 19 85			
22b. SIGNATURE		DEGREE										22c. DATE SIGNED			
Bruce A. Silver, MD															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
BRUCE A. SILVER, MD		106 Irving St, NW, DC 20010													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			CITY OR TOWN		COUNTY		STATE	
BURIAL		1/2/86		GATE OF HEAVEN			SILVER SPRING			SILVER SPRING		MONT		MD.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE			
FRANCIS J. COLLINS, JR.		JAN 6 1986										John Davidson-Pandrea			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901															



354079

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 5 2 1 2

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
LUCYE VALENTINE McINTEER				DECEMBER 15, 1985		4:55 AM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS			
FEMALE		WHITE		FEBRUARY 14, 1917		68		IF UNDER 24 HRS MONTHS DAYS			
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
WASHINGTON, D.C.		U.S.A.				MONTGOMERY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
ROCKVILLE		6105 CROSSOVER LANE		ADMIN. ASST.		COMPUTER CO.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
MARYLAND		MONTGOMERY		ROCKVILLE				6105 CROSSOVER LANE 20852			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. ADDRESS				
VALENTINE		J.	ISEMANN		LUCYE	MARGARET	SMITH				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO		579-42-7531		BARBARA SCHAEFER, DAUGHTER, SAME AS ITEM #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>COPD</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		22a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
		P.M. 19						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/1/12</u> to <u>12/15/85</u> , that (II) (we) last saw the deceased alive on <u>12/12/1985</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (II) (we) did not view the body after death.		22b. SIGNATURE		22c. DEGREE		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						12/15/85			
MARK F. EG, M.D.		5801 GEORGIA AV Silver Spring, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		12/17/85		FORT LINCOLN CEMETERY		BLADENSBURG P.G. MD.					
24. FUNERAL DIRECTOR NAME		RICHARD RAPP, INC.		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
1804 T ST., N.W., WASHINGTON, D.C. 20009						DEC 18 1985		MARK F. EG, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed by the attending physician and certified by the funeral director, page 4 may be

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and certified by the funeral director, page 4 may be  
should be detached for use as the burial permit. Then please remove carbon copies. Please return the original to the  
with the State Dept. of Health and Mental Hygiene after a burial, cremation, or removal.

IMPORTANT If item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical



1968 C-1968 NOT TO



008026

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 35210

1 - STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Frances					McKay	12-27-85				6:25 p.m.			
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female			Black	MONTH	DAY	YEAR	57						
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
N.C.			U.S.A.						Montgomery				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
Takoma Park			Washington Adventist Hosp.			Unemployed						20903	
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Md.			Montgomery			YES <input type="checkbox"/> NO <input type="checkbox"/>			10129 New Hampshire # T-1				
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			LAST				
Charlie Bohannon						Delphine Cuttrell							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No						General Budd (sister)			18401 Manchester Rd. Terwood, Md. 20855			1-2 days	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) hepatitis													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) <input type="checkbox"/> (we) <input type="checkbox"/> attended the deceased from 12-18-1985 to 12-27-1985, that (I) <input type="checkbox"/> (we) <input type="checkbox"/> last saw the deceased alive on 12-27-1985, and that in (my) <input type="checkbox"/> (our) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death.													
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
Fr. Brennert												12-30-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			831 University Blvd E. Silver Spring							
Fr. Brennert													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN				
Removal			1-2-86			Gilmore Funeral Home			Winston-Salem, NC				
24. FUNERAL DIRECTOR NAME			246 N. Washington Street			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
George R. Snowden			Rockville, MD 20850									JAN 3 1986 John B. Johnson	

250600

RECORDED - INDEXED - SERIALIZED - FILED



365274

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 21 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM ITEM 3. PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

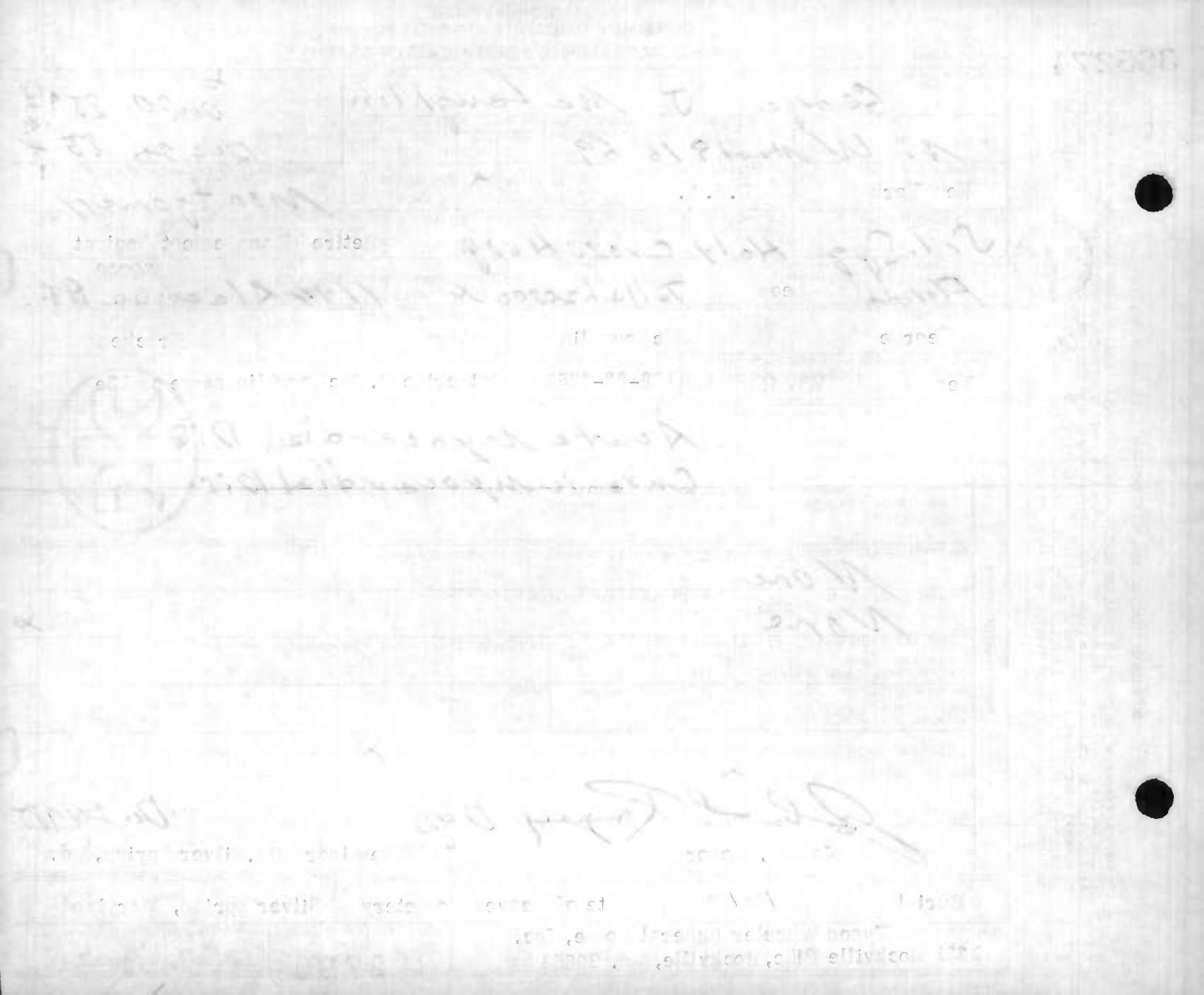
## MEDICAL CERTIFICATION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

35214

REG. NO.

1 - STATE REGISTRAR		2a. DATE KNOWN TO MONTH DAY YEAR OF ESTIMATE DEATH MATED MONTH DAY YEAR													
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST			2b. DATE KNOWN TO MONTH DAY YEAR OF ESTIMATE DEATH MATED MONTH DAY YEAR					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD									
10. CITY OR TOWN OF DEATH S. I. Sp. Holy Cross Hosp		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Management Analyst			
13a. STATE Florida		13b. COUNTY Leon		13c. CITY OR TOWN Tallahassee		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11440 Bracken St.		12b. KIND OF BUSINESS OR INDUSTRY					
14. FATHER'S NAME George		15. MOTHER'S MAIDEN NAME Anna													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II		16c. INFORMANT Catherine E. McLaughlin same as 13e											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <i>Acute myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.  (b) <i>Chronic myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF  (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  <i>None</i>															
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) <i>John S. Rogers, M.D.</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers</i>												MEDICAL EXAMINER ADDRESS 1919 Seminary Rd. Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/24/85		23c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN Silver Spring, Maryland		23e. COUNTY		STATE					
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852		25a. DATE REC'D. BY REGISTRAR DEC 27 1985		25b. REGISTRAR'S SIGNATURE <i>Laura Davidson Pendleton</i>											



347076

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 8, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. TO FUNERAL DIRECTOR, PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3521		
1- STATE REGISTRAR			DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH DAY YEAR	2b. HOUR	
			FRANCES H MC LAURIN						<input checked="" type="checkbox"/> 12 06 85				5:30 PM	
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YR.		8 IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		
FEMALE		WHITE		OCTOBER 28, 1919		66 yrs.		MONTHS DAYS		HOURS MIN.		12 06 85		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9 BALTIMORE CITY OR COUNTY OF DEATH		
Mississippi		United States		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		MONTGOMERY COUNTY		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS INDUSTRY					
BETHESDA			SUBURBAN HOSPITAL			Secretary			Data Research					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
MARYLAND		MONTGOMERY		CHEVY CHASE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			3615 CHEVY CHASE LAKE DR 20815					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Francis			H. McLaurin			425 10 4106			Jean McLaurin (Sister)			3615 20815 Chevy Chase Drive Chevy Chase, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>coronary arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>John Tanber</u>			TITLE (SPECIFY) M.D. <u>Dopty</u>			MEDICAL EXAMINER			DATE SIGNED <u>12-6-85</u>					
EXAMINER'S NAME (TYPE OR PRINT) <u>John Tanber</u>			ADDRESS <u>8218 WISCONSIN AVE</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>			23b. DATE <u>DECEMBER 8, 1985</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>METROPOLITAN CREMATORIUM</u>			23d. LOCATION CITY OR TOWN <u>ALEXANDRIA, VIRGINIA</u>			COUNTY		STATE
24 FUNERAL DIRECTOR NAME <u>ROBERT A. PUMPHEY FUNERAL HOMES PA</u>			25a. DATE REC'D. BY REGISTRAR <u>DEC 11 1985</u>			25b. REGISTRAR'S SIGNATURE <u>John Tanber</u>								
7557 WISCONSIN AVENUE BETHESDA, MARYLAND 20814														





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit stamp. Then please remove carbon paper. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 contains any injury or other traumatic event, the medical examiner may be notified.

358018

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 3521

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR					
<b>G. Burroughs</b>					<b>Mider</b>	<b>12 - 13 - 85</b>				<b>3:15AM</b>					
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR			# UNDER 24 HRS						
<b>Male</b>	<b>Caucasian</b>	<b>August 9, 1907</b>			<b>78</b>	MONTHS	DAYS	YRS	HOURS	MIN.					
7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
<b>New York</b>	<b>United States</b>				<b>Montgomery County</b>										
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY				
<b>Olney</b>	<b>Montgomery General Hospital</b>					<b>Physician</b>					<b>U.S. Gov't National</b>				
13a. STATE <b>Maryland</b>											13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Silver Spring</b>	13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	13e. STREET ADDRESS / ZIP CODE <b>15301 Pine Orchard Drive / 20906</b>	Institutes of Health
14. FATHER'S NAME	FIRST <b>Carroll</b>	MIDDLE	LAST <b>Mider</b>	15. MOTHER'S MAIDEN NAME			FIRST <b>Elizabeth</b>	MIDDLE	LAST <b>Pawson</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT (Wife) <b>Ruth L. Mider</b>			ADDRESS <b>15301 Pine Orchard Dr Silver Spring, MD 20906</b>									
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiovascular Disease</i>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>				
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bone Marrow Transplant</i>															
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Respiratory Failure</i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Renal Cell Carcinoma, Partial Leucemia, Bone Marrow Disease</i>															
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>12/11/85</b> to <b>12/13/85</b> , 19 <b>85</b> , to <b>12/13/85</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>12/13/85</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I was (we) did not) view the body after death.															
22b. SIGNATURE <i>Daniel Goldberg</i>															
22c. DEGREE															
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>															
22d. DATE SIGNED <b>12/13/85</b>															
22e. ADDRESS <b>1040 Old Georgetown Rd - Bethesda, Md 20814</b>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION												
<b>Cremation</b>	<b>December 14, 1985</b>	<b>Metropolitan Crematory</b>	<b>Alexandria</b>												
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. 7557 Wisconsin Avenue, Bethesda, Maryland															
25a. DATE REC'D. BY REGISTRAR <b>DEC 20 1985</b>															
25b. REGISTRAR'S SIGNATURE															

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JULY 1962

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Please, I and my family would like to be laid within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or embalming.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

365113

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)	FIRST <b>MARY</b>	MIDDLE <b>W.</b>	LAST <b>MILLER</b>	2a. DATE OF DEATH <b>DECEMBER 21, 1985</b>	MONTH YEAR	DAY	YEAR	2b. HOUR <b>5:00 pm</b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH <b>AUG.</b> DAY <b>7,</b> YEAR <b>1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b>				
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>9527 CLEMENT ROAD</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>REGISTERED NURSE</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD.</b>	13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>SILVER SPRING</b>	13d. INSIDE CITY LIMITS? <b>NO</b>	13e. STREET ADDRESS <b>9527 CLEMENT RD.</b>		<b>20910</b>		
14. FATHER'S NAME FIRST <b>WILLIAM</b>	MIDDLE <b>NEWTON</b>	LAST <b>WOLFE</b>	15. MOTHER'S MAIDEN NAME FIRST <b>SYBELLE</b>	MIDDLE	LAST	<b>MULLENIX</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>VFS</b>	16b. SOCIAL SECURITY NO. <b>WW II 578-38-8059</b>	17. INFORMANT DAUGHTER <b>LOURETTE MORAN</b>	ADDRESS <b>1008 WOODBERRY SOUTH EDMOND, OKLAHOMA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Carcinoma lung left</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>with metastases.</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 19 85</b> , to <b>Dec 19 85</b> , that (I) (we) last saw the deceased alive on <b>Dec 17 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Javed Rahmat</i>	DEGREE <b>M.D.</b>	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>12/22/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAVED RAHMAT</b>	22e. ADDRESS <b>4905 DEL RAY AVE BETHESDA - MD 20814</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>12/26/85</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>GATE OF HEAVEN</b>	23d. LOCATION CITY OR TOWN <b>SILVER SPRING</b>	23e. COUNTY <b>MONT</b>	23f. STATE <b>MD.</b>			
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS, JR.</b>	25a. DATE RECD. BY REGISTRAR <b>DEC 27 1985</b>			25b. REGISTRAR'S SIGNATURE <i>W. K. K.</i>				
500 UNTV. BLVD., W., SILVER SPRING, MD. 20901								

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGE 1 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. TO FUNERAL DIRECTOR, PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT; PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												35219	
												REG. NO.	
1- STATE REGISTRAR			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 12 1 1985									2b. HOUR <input type="checkbox"/> 2d HOUR <input checked="" type="checkbox"/> 4:40 p.m.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST				
KEVIN L. MILTENBERGER													
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
Male Caucasian		Dec. 23 59 25 yrs.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE PRONOUNCED DEAD MONTH DAY YEAR		9. BALTIMORE CITY OR COUNTY OF DEATH			
W. Virginia		U.S.A.						12 1 1985		Montgomery County			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Silver Spring			909 Whitehall Street									Stockbroker	
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 909 Whitehall Street 20901	
14. FATHER'S NAME FIRST Gordon			MIDDLE L.			LAST Miltenberger			15. MOTHER'S MAIDEN NAME FIRST Dolores			LAST A. Dalton	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT (Father)			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO			219-68-4741			Gordon L. Miltenberger Same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforating gunshot wound of head (handgun)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? Head Only <input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 12-1- 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self-inflicted.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home			21f. LOCATION STREET 909 Whitehall Way, Silver Spring, Montgomery, MD CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Ann M. Dixon, M.D.</u>													
EXAMINER'S NAME (TYPE OR PRINT)												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
ADDRESS 111 Penn St., Balto., MD 21201												DATE SIGNED 12-2-85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN Silver Spring, Mont.			STATE Maryland	
Burial			Dec. 4, 1985			Gate of Heaven							
24. FUNERAL DIRECTOR NAME			Francis J. Collins									23e. DATE REC'D. BY REGISTRAR 1 DEC 5 1985	
500 University Blvd. W. Silver Spring, Md. 20901												23f. REGISTRAR'S SIGNATURE	
07/84 25M		BP		DHMH - 17 (VR A15 ME (5))									

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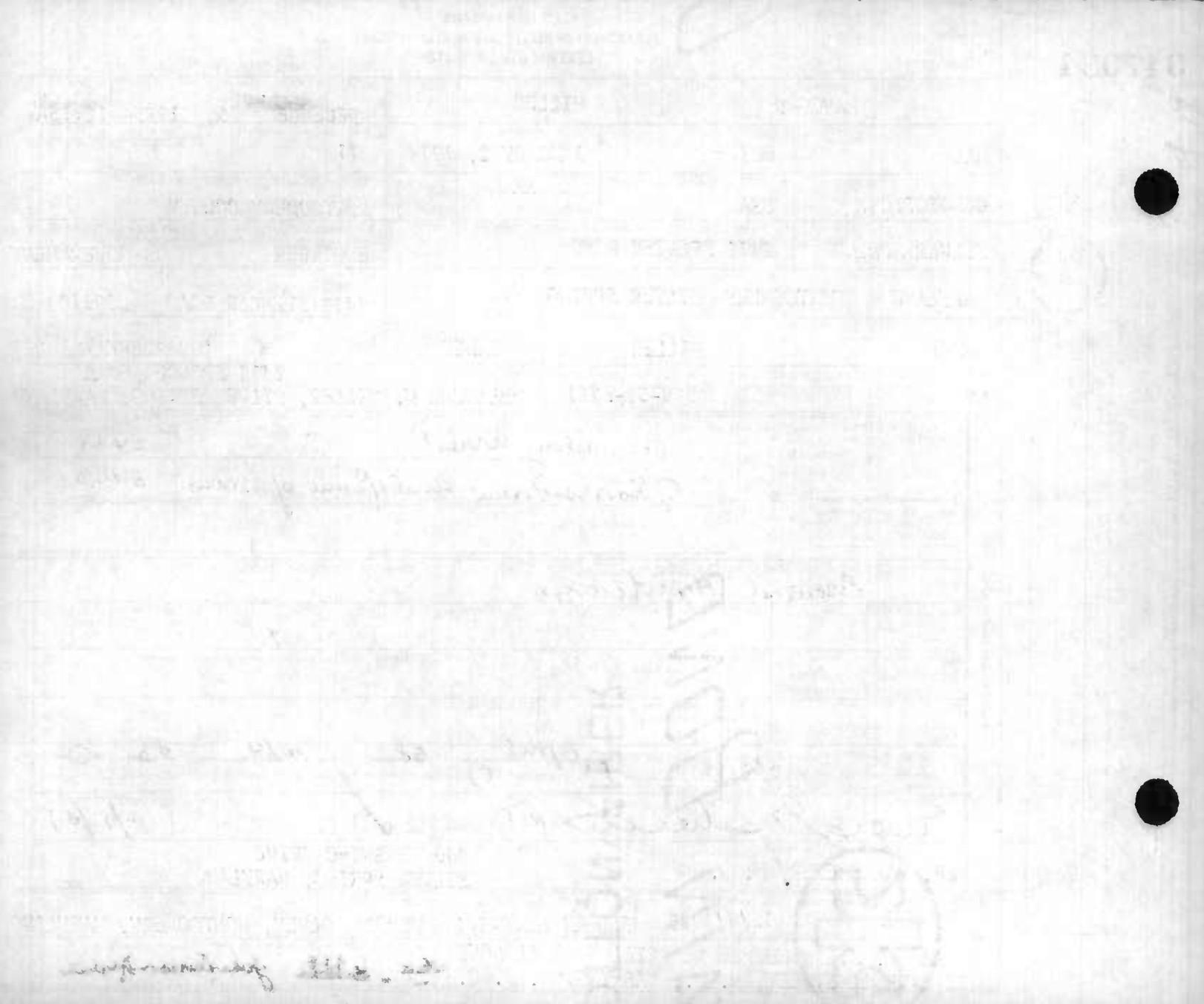
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 showed any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										35	35	20
										REG. NO.		
1. FOR STATE REGISTRAR	FIRST RAYMOND	MIDDLE MILLER	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
1 DECEASED NAME (TYPE OR PRINT)				DECEMBER	5,	1985		12:15 AM				
3. SEX MALE	4. RACE WHITE	S. DATE OF BIRTH JANUARY 02, 1914	6. AGE (IN YEARS LAST BIRTHDAY) 71	IF UNDER 1 YEAR MONTHS DAYS				# UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE COUNTRY CONNECTICUT	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.									
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 2412 SPENCER ROAD	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER	12b. KIND OF BUSINESS OR INDUSTRY US GOVERNMENT									
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2412 SPENCER ROAD 20910								
14. FATHER'S NAME MORRIS	MIDDLE MILLER	15. MOTHER'S MAIDEN NAME MINNIE	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO	16b. SOCIAL SECURITY NO. 579-38-6781	17. INFORMANT ADVISER BLANCHE M. MILLER, SILVER SPRING, MARYLAND							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Globotuloma Encephaliforme of Brain</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET & DEATH 24 hr.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Essential hypertension</i>										5 mo.		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE							
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>Oct 15</u> 19 <u>85</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	April 19 56 to 214 19 85											
22b. SIGNATURE <i>Max Sherer</i>	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 2/15/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. MAX SHERER, M. D.	22e. ADDRESS 800 PERSHING DRIVE SILVER SPRING, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL ISPE BURIAL	23b. DATE 12/6/1985	23c. NAME OF CEMETERY OR CREMATORIAL JUDEAN. MEMORIAL GARDENS	23d. LOCATION CITY OR TOWN OLNEY, MONTGOMERY, MARYLAND									
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.					25a. DATE REC'D. BY REGISTRAR 12/6/85	25b. REGISTRAR'S SIGNATURE <i>Juda Stein</i>						



358055

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 35221

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Winfred			E.		Mister	12/18/85			12:18 85	643 4M	
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male		White	MONTH	DAY	YEAR	65	MONTHS	DAYS	# UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County			
Virginia		U.S.A.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park		Washington Adventist Hospital			Owner			Appliance Business			
13a. STATE Maryland						13b. COUNTY P.G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
										13e. STREET ADDRESS / ZIP CODE 6017 Jamestown Road 20782	
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST		
William			Franklin	Moore	Ida			May	Moore		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT (Wife) Mildred G. Mister			ADDRESS Same as #13		
Yes-Marines			W.W.II			230-01-8543					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>REPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PARKINSON DISEASE, Bulbar Palsy</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) <u>5 yrs</u>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 26 MIN											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) TRACH ECTOMY, CORD											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (1) this hospital attended the deceased from 11 AM, 1985, to 1 PM, 1985, that (1) we lost sow the deceased alive on 12/16/1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) we did (1) did not view the body after death.											
22b. SIGNATURE <u>JR Elman</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DATE SIGNED <u>1/18/86</u>											
22c. PHYSICIAN'S SIGNATURE (PRINT)		22d. ADDRESS <u>6521 BILLARD RD, Hyattsville MD</u>									
23a. BURIAL, CREMATION, REMOVAL (IF ANY)		23b. DATE Burial 12/21/85		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brentwood		23e. COUNTY P.G.	23f. STATE Maryland		
24. FUNERAL DIRECTOR NAME Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781					25a. DATE REC'D. BY REGISTRAR DEC 20 1985			25b. REGISTRAR'S SIGNATURE <u>John Pendle</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be used within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical certificate must be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be filed in by the funeral director, page 3 should be detached for use at the burial/transit permit. Then please remove carbon paper. Item 21 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT:

If item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85	35	222							
										REG. NO.									
1 - STATE REGISTRAR			2a. DATE OF DEATH							MONTH	DAY	YEAR	2b. HOUR						
1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	Dec. 27, 1985							1:15 A.M.						
Florence F. Mitchell																			
3 SEX			4 RACE		5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Female			Caucasian		March 21, 1901			84				MONTHS DAYS		HOURS MIN.					
7a BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH							
Unknown			United States									Montgomery County, MD.							
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Rockville			Rockville Nursing Home							Homemaker				Home					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e. STREET ADDRESS / ZIP CODE			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			617 Aster Blvd. Rockville, Maryland 20850											
Maryland			Montgomery		Rockville														
14 FATHER'S NAME			MIDDLE		LAST			15. MOTHER'S MAIDEN NAME				ADDRESS							
FIRST			Unknown					FIRST				H. W. Clarkson 401 Russell Avenue Gaithersburg, Maryland 20877							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
No			318-01-1109									Cardiac Arrest				Minutes			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			(b)		Arteriosclerotic Heart Dis							4 Years							
			(c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
			P.M. 19																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>12/26</u> , 19 <u>85</u> , to <u>12/26</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>12/26</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE			DEGREE							ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED						
													Dec. 27, 1985						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							4115 Colie Dr. Wheaton, Maryland									
Raymond T. Benack, M.D.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN				COUNTY		STATE					
Cremation			December 27, 1985		Metropolitan Crematory			Alexandria, Virginia											
24 FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR							25b. REGISTRAR'S SIGNATURE									
Robert A. Pumphrey Funeral Homes PA			JAN 3 1986							Randall									
300 West Montgomery Ave Rockville, Maryland 20850																			

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RECEIVED  
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CIRCULATION SECTION

014166

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 353523

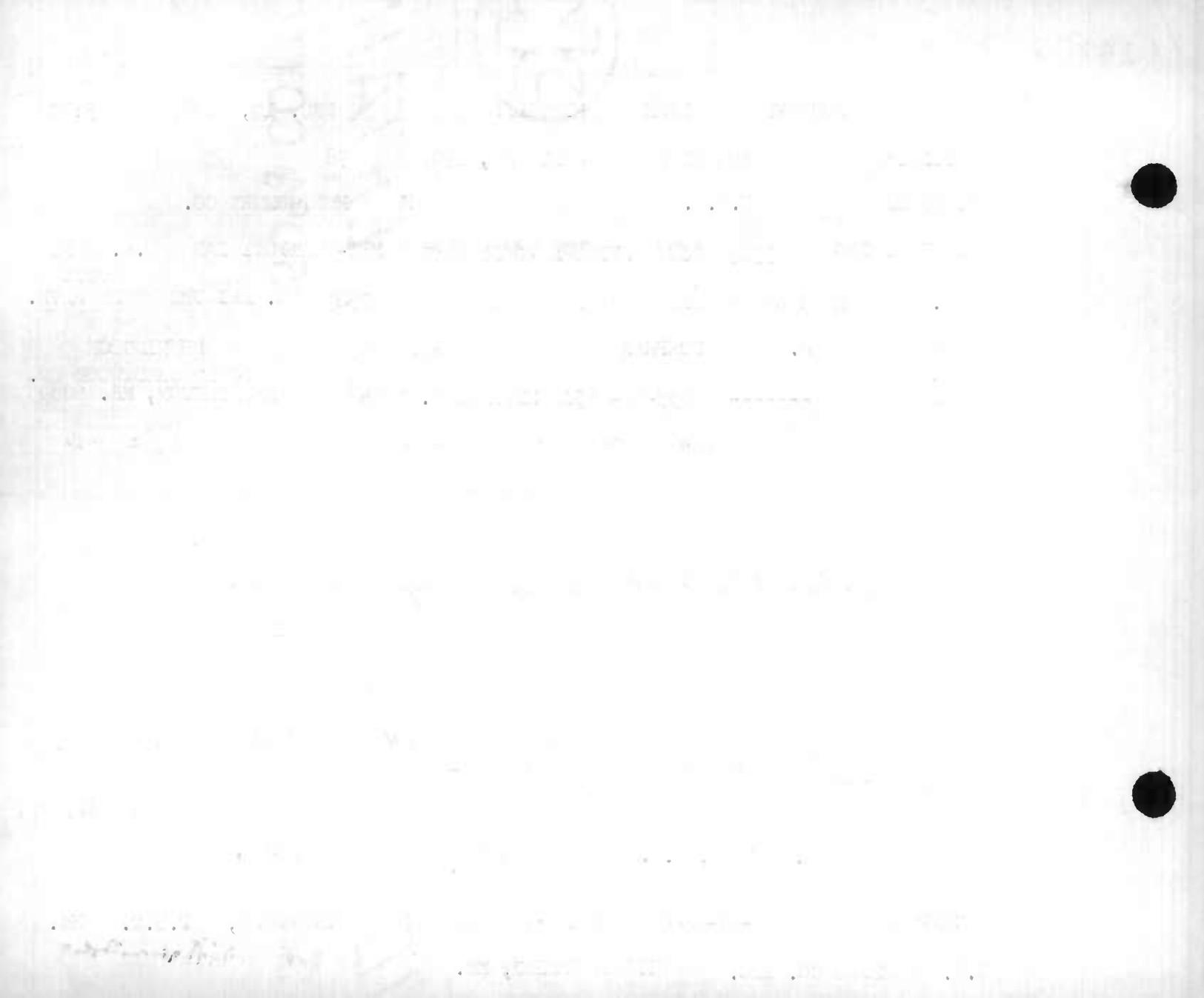
1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR		
			KATHERYN	DEAN	MITCHELL	DEC. 12, 1985			5:40AM			
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
FEMALE			CAUCASIAN	JULY 27, 1907			78			MONTHS DAYS HOURS MIN.		
7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
VIRGINIA			U.S.A.				MONTGOMERY CO.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING			3383 SOUTH LEISURE WORLD BLVD			RET-STATISTICIAN			U.S. ARMY			
13a. STATE			13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 20906		
Md.			MONTGOMERY	SILVER SPRING						3383 SO. LEISURE WORLD BLVD.		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST			
			OSCAR	C.	STEPHEN	CATHERINE			DUNNINGTON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
(YES, NO OR UNKNOWN)			455-14-4651			MYRILYN A. BARR			10012 CRESTWOOD RD. KENSINGTON, Md. 20895			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Adenos carcinoma of colon						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)						2 yrs.			
			DUE TO, OR AS A CONSEQUENCE OF (b)									
			DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			Lung failure 2 <sup>nd</sup> metastatic disease, myeloproliferative disorder									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 2 Dec 1985, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.			May 1984 to 12 Dec 1985									
22b. SIGNATURE Donald E. Dillon, M.D.			DEGREE						22c. DATE SIGNED 12 Dec 1985			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon, M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 12-13-1985			23c. NAME OF CEMETERY OR CREMATORIAL CHAMBERS CREMATORY			23d. LOCATION CITY OR TOWN RIVERDALE, P.G.C. Md.			
24. FUNERAL DIRECTOR NAME W.W. CHAMBERS CO. INC.			ADDRESS SILVER SPRING, Md.			25a. DATE REC'D. BY REGISTRAR JAN 13 1986			25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 may be retained by the funeral director or removed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, an attorney or medical examiner should be consulted before signing this certificate.



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, REF. IN PAGE 4, WHICH IS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	XX MONTH DAY YEAR	10:30 P M	
Margaret S. Mohler						<input checked="" type="checkbox"/>	Dec 17, 1985		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH DAY YEAR	10:30 P M	
Female	Caucasian	March 22, 1904	81 yrs.			December 17 1985			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Pennsylvania		United States		NEVER MARRIED DIVORCED <input type="checkbox"/>		Montgomery County			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Kensington			Kensington Gardens Nursing Home			Homemaker		Own Home	
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 12630 Viers Mill Road 20853		
14. FATHER'S NAME FIRST Peter			MIDDLE	LAST Schwarz	15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE	LAST Keller	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT (Son) Stratton Court			
No			N/A 193-14-8250			Irvin C. Mohler Jr, Rockville, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I DEATH WAS CAUSED BY:  888 IMMEDIATE CAUSE (a) <u>Cardio Respiratory arrest</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Coronary arteriosclerosis</u> . (c) <u>Fractured Pelvis</u> .									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 16 7 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 7x11			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home.			21f. LOCATION STREET CITY OR TOWN Montgomery County, MD. 12630 Viers mill RD Rockville			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									DATE SIGNED December 18, 1985
ACTUAL SIGNATURE <u>John F. Tauber</u>			TITLE (SPECIFY) M.D. <u>John F. Tauber</u> MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 8218 Wisconsin Avenue, Bethesda, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE December 18, 1985			23c. NAME OF CEMETERY OR CREMATORIUM Metropolitan Crematory		23d. LOCATION CITY OR TOWN Alexandria	COUNTY Virginia
24. FUNERAL DIRECTOR NAME P.A. 300 W. Montgomery Avenue, Rockville, MD						25a. DATE REC'D. BY REGISTRAR DEC 23 1985		25b. REGISTRAR'S SIGNATURE <u>Janet Warden-Pender</u>	



**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-1, RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 CAN BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. LUDWIG STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, Cremation, OR REMOVAL.

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
Carlos W. Molina						Dec 5, 1985	19:30 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	9. DATE PRONOUNCED DEAD	10. DATE OF DEATH MONTH DAY YEAR
M	W	06.26.84	YRS.			Dec 5, 1985	19:30 P.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH	
Washington, D.C.		U.S.A.		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		Montgomery MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Olney		Montgomery Hospital				Infant	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS	20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Md	Montgomery	55188		14221 George Washington	20:00		
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		21. KIND OF BUSINESS OR INDUSTRY	
Carlos		Guillermo	Molina	Juana		Infant	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		None		Juana Molina		Same as items 13a-e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Seizure Disorder</i>							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>DUE TO, OR AS A CONSEQUENCE OF</i> (c) <i>DUE TO, OR AS A CONSEQUENCE OF</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) <i>None</i>							
19a. DATE OF OPERATION <i>None</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held on <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 1919 Seminary Rd. Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 12/7/85	23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven		23d. LOCATION CITY OR TOWN Silver Spring, Maryland	23e. COUNTY	STATE
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 20852		25a. DATE REC'D. BY REGISTRAR DEC 13 1985		25b. REGISTRAR'S SIGNATURE <i>Jane Dawson Pendleton</i>			

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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

55228

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**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, REBURNAGE, FOR YOUR FILES.

DIVISION OF VITAL RECORDS 201 W BOSTON ST MONTGOMERY AL 36101

1. DECEASED NAME (TYPE OR PRINT)		FIRST MARION K.		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH DAY			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE IN YEARS LAWSUIT (DAY) YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		8. DATE PRONOUNCED DEAD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD		MONTH DAY			
10. CITY OR TOWN OF DEATH Baltimore MD		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 158-18-5303 Inv St		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BRANCH CHIEF		12b. KIND OF BUSINESS DEPT OF LABOR		20902			
13a. STATE MD		13b. COUNTY Mont		13c. CITY OR TOWN 158-18-5303		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 10303 Inv St			
14. FATHER'S NAME FIRST JAMES		MIDDLE FRANCIS		LAST KERR		15. MOTHER'S MAIDEN NAME JEAN MARIAN LASKOWSKI					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 158-18-5307		17. INFORMANT ROBERT T. MONAHAN		ADDRESS SAME AS 13 HUSBAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) Acute Myocardial D.I.S.  Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 None											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
TITLE (SPECIFY) ACTUAL SIGNATURE John S. Rogers M.D. MEDICAL EXAMINER											
DATE SIGNED Dec 24/85											
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS		ADDRESS 1919 SEMINARY RD., SILVER SPRING, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) ENTOMBMENT		23b. DATE 12/27/85		23c. NAME OF CEMETERY OR CREMATORIAL GATE OF HEAVEN MAUSOLEUM		23d. LOCATION CITY OR TOWN SILVER SPRING		COUNTY MONT			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.		24b. DATE REC'D. BY REGISTRAR JAN 02 1986		24c. DATE REC'D. BY REGISTRAR		24d. REGISTRAR'S SIGNATURE					
500 UNTV. BLVD. W. SILVER SPRING, MD. 20901											



1863

John D. Dix

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the physician be informed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

008089

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 3535221

1 - FOR STATE REGISTRAR																		
1 DECEASED NAME (TYPE OR PRINT)			FIRST JOHN			MIDDLE EDWIN			LAST MOORE			2a. DATE OF DEATH DECEMBER 29, 1985		MONTH	DAY	YEAR	2b. HOUR 3:22 A	
3. SEX MALE			4 RACE WHITE			5. DATE OF BIRTH MONTH DECEMBER DAY 8, YEAR 1927			6 AGE (IN YEARS LAST BIRTHDAY) 58 YRS			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN				
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Texas			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.									
10 CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Staff Administrator U.S. Gov't			12b KIND OF BUSINESS OR INDUSTRY									
13a. STATE D. C.			13b. COUNTY WASHINGTON			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 614 FOURTH PLACE, SW 20024									
14 FATHER'S NAME John			MIDDLE E. LAST Moore			15 MOTHER'S MAIDEN NAME Juliette			16 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b SOCIAL SECURITY NO. Korea 450-34-7169			17 INFORMANT MRS. JOYCE P. MOORE (WIFE) SAME AS PT			ADDRESS									
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b1, and 1c1.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			RESPIRATORY ARREST															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF (b) DIFFUSE UNDIFFERENTIATED LYMPHOMA						1 Year									
			DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from AUGUST 17, 19 84, to DECEMBER 29, 19 85, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 29, 19 85, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> view the body after death.																		
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED DEC. 29, 1985									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NORMAN LASSAM, MD			22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD 20892															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-31-85			23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cemetery Arlington, Virginia			23d. LOCATION CITY OR TOWN COUNTY STATE									
24 FUNERAL DIRECTOR NAME Arlington Funeral Home			ADDRESS Arlington, Virginia			25a. DATE REC'D. BY REGISTRAR JAN 2 1986			25b. REGISTRAR'S SIGNATURE Julie Deirdre Pendell									
DHMH - 16 60M 7/84 (VRA 15, 4)																		

Q3960



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please retain the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or either traumatic or non-traumatic, the medical examiner must be notified at once.

365290

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												5	3	5	2	2	3
1. FOR STATE REGISTRAR			REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
GEORGE			PETER	MORFOGENIS				DECEMBER 12, 1985						5:57 P M			
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
MALE			WHITE		MONTH DAY YEAR			64			MONTHS	YEARS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
NEW YORK			USA		JULY 9, 1921			MONTGOMERY COUNTY									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA			NIH, THE CLINICAL CENTER									INDUSTRIAL ENG.			ENGINEERING		
13a. STATE NEW YORK			13b. COUNTY		13c. CITY OR TOWN LONG ISLAND			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE P.O. BOX 11, KINGS PARK 11754			59 HILDEN ST.			
14. FATHER'S NAME PETER			MIDDLE	LAST			15. MOTHER'S MAIDEN NAME ELIZABETH			MIDDLE				ARNOITIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES			16b. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT			ADDRESS									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			SUDDEN MULTI ORGAN FAILURE - HEART, LUNG, LIVER, KIDNEY									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			DUE TO, OR AS A CONSEQUENCE OF (b) POSSIBLE SEPSIS									6 DAYS					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION NOVEMBER 22, 1985			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CORONARY ARTERY DISEASE						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from OCTOBER 5, 1980, to DECEMBER 12, 1985, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 12, 1985, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (not) view the body after death.																	
22b. SIGNATURE <i>Richard H. Kornblau</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED DEC. 12, 1985						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Richard H. Kornblau</i>			22e. ADDRESS NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20892														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12/17/85			23c. NAME OF CEMETERY OR CREMATORIUM CYPRESS HILLS			23d. LOCATION BROOKLYN			COUNTY NEW YORK					
24. FUNERAL DIRECTOR MARSHALL'S FUNERAL HOME WASH, D.C. 20011			4217 9TH ST. N.W. AUGUST			25a. DATE REC'D. BY REGISTRAR DEC. 19, 1985			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>								
999999 DMH&H 16 JUN 7/84 (VRA 15, 4)																	

DISRAELI



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or if item 18 shows an injury, or other traumatic event, the medical examiner

006176

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 5 35229

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Paul</i>	MIDDLE <i>T. K.</i>	LAST <i>Mui</i>	2a DATE OF DEATH MONTH YEAR	2b HOUR 12 21 85 9:52 AM		
3. SEX <i>Male</i>			4. RACE <i>Chinese</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>7 - 19-1942</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <i>43</i>	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Canton, China</i>			7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County MD.</i>			
10. CITY OR TOWN OF DEATH <i>Wheaton</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>University Nursing Home</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>PhD in Research</i>			
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Silver Spring</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>12920-Georgia Avenue 20906</i>			
14. FATHER'S NAME FIRST <i>Chong</i>			MIDDLE <i>Job</i>	LAST <i>Moy</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Toy</i>	MIDDLE <i>Tuet</i>	LAST <i>Oy</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>215-52-8451</i>			17. INFORMANT ADDRESS <i>Michael C. Moy (Nephew) 2209-Deckman Lane, Silver Spg., MD 20906</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))			<i>Pneumonia x 4 days</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Glioblastoma x 2 years</i>						
			DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF YES, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>December 19 83</i> to <i>December 21 1985</i> , that (I) (we) last saw the deceased alive on <i>December 20 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not observe the body after death.									22c. DATE SIGNED <i>Dec. 21, 1985</i>
22b. SIGNATURE <i>Walter Goorh MD</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Walter Goorh MD</i>		22e. ADDRESS <i>2309 Shorefield Rd Wheaton Md</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Dec. 24, 1985</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven Cem.</i>		23d. LOCATION CITY OR TOWN <i>Silver Spring, Montgomery Co., MD</i>		STATE	
24. FUNERAL DIRECTOR NAME <i>Lee Funeral Home</i>		ADDRESS <i>300-4th St., NE Wash., DC 20002</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 30 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Johann Johnson</i>			



006175

## DIVISION OF VITAL RECORDS, 201 W. PPRENTISS, BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER FORM. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRENTISS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												35230	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			10 MONTH DAY YEAR	2b. HOUR 1020 A M			
Annie M. Myers				M.	Myers	Dec 21, 1985			10 MONTH DAY YEAR	1020 A M			
3. SEX		RACE	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR	8. IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			2d. DATE RECD. BY REGISTRAR		
F		CW	AN	Nov 401 89 yrs	89 yrs	MONTHS DAYS	HOURS MIN	Dec 22, 1985			2000		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			2e. REGISTRAR'S SIGNATURE		
Georgia		United States						Montgomery MD.			J. William Lee's Sons Co.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN HOSPITAL FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			Retired-Bank teller Banking		
Silver Spring		Hilltop Convalescent Hosp						4521-East West Highway			70901		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		ADDRESS			
Maryland		Montgomery		Bethesda		YES <input checked="" type="checkbox"/>		4521-East West Highway		Silver Spg, MD 20902			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
John		Millard		Fillmore		Mary		T.		Pursley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		577-30-0047		Mary Anne Koutsoukos (Niece)		Acute myocardial Dis.		1800-August Dr.					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF		(b)		Chronic myocardial Dis.		Yrs.					
(c)		DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
None		19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) John S. Rogers, M.D.	
ACTUAL SIGNATURE												MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)												DATE SIGNED Dec 20, 1985	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		Dec. 23, 1985		Cedar Hill Cemetery		Suitland		Prince George Co., MD					
24. FUNERAL DIRECTOR NAME		ADDITIONAL NAME		20002		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
J. William Lee's Sons Co.		300-4th St., NE, Wash., DC		DEC 30 1985									

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1

Geometric Categories

Replies - before telling you

Wet NH<sub>4</sub><sup>+</sup> Measured by colorimetry  
Best method for Sulfuric acid

*Verlag der Gesellschaft für Volkskunde Berlin*

2522-3C-00472 MARY ANN KIRTEGREN (Miles/1800-7454)

John G. Roberts, CM, Telia-Geometria AB, Diagonal 50, Lund, Sweden

Dec. 53, 1982 Geiger Hill Geophysics and Testing, Inc., Geophysics Co., Inc.

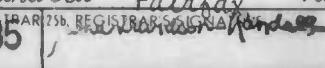
Multi-layered Bee-eater G.O.300-45B S.F. NH-Nearby DC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

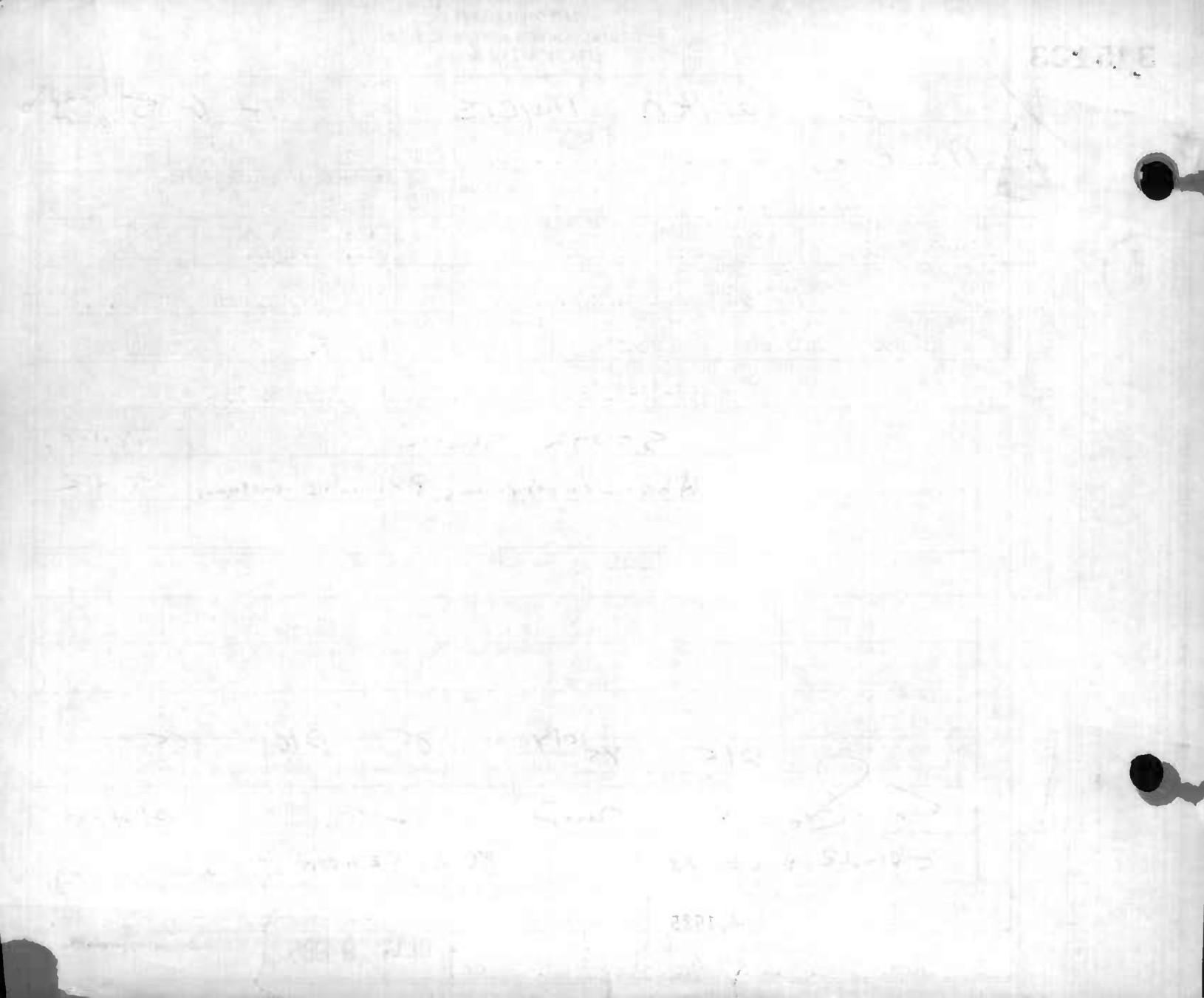
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as "No" sawing the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8535231
1. FOR STATE REGISTRAR -  345123	2. DECEASED NAME (TYPE OR PRINT)  E. Carlton Myers			REG. NO. 8535231
3. SEX  Male	4. RACE  Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Feb. 3, 1928	6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	7. DATE OF DEATH MONTH DAY YEAR 12 6 85 HOUR 12 PM
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	9. CITIZEN OF WHAT COUNTRY? U.S.A.	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	11. CITY OR TOWN OF DEATH Silver Spring	
12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		13. DUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gen. Manager		
14. FATHER'S NAME FIRST MIDDLE LAST Elmer Carlton Myers		15. MOTHER'S MAIDEN NAME Dorothy F. Koone		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 498-26-8209	17. INFORMANT Son John C. Myers	18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 44 HRS.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		19. DUE TO, OR AS A CONSEQUENCE OF (b) <u>HepatoCarcinoma, Primary Melanoma</u>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		19. DUE TO, OR AS A CONSEQUENCE OF (c) _____		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
20a. DATE OF OPERATION	20b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>12/6/85</u> , 19 <u>85</u> , to <u>12/6</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>12/6/85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.				
22b. SIGNATURE 	22c. DEGREE M.D.	22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22e. DATE SIGNED 12/6/85	
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Edward A. Legion	22g. ADDRESS 8620 PERRY ST., Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE Dec. 6, 1985	23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan	23d. LOCATION CITY OR TOWN Alexandria	STATE Va.
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 Univ. Blvd. W., Silver Spring, Md. 20901	25a. DATE REC'D. BY REGISTRAR DEC 9 1985	25b. REGISTRAR'S SIGNATURE 		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Form 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 85 35232		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2d. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR A 10:05M
EDITH LOUISE NASH							DECEMBER 9, 1985					
3. SEX FEMALE			4 RACE CAUCASIAN	5. DATE OF BIRTH JUNE 21, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SAN JOSE, CALIF.			7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.						
10. CITY OR TOWN OF DEATH SANDY SPRING			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRIENDS NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE		12b. KIND OF BUSINESS OR INDUSTRY RETIRED			
13. STATE MARYLAND			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SANDY SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 17330 Quaker Lane 20860				
14. FATHER'S NAME WARREN			MIDDLE	LAST NASH		15. MOTHER'S MAIDEN NAME ALICE		MIDDLE		LAST WOOD		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None			16b. SOCIAL SECURITY NO. 115-14-9911		17. MANNER OF DEATH 8209 Custer Rd. Bethesda, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Congestive cardiomyopathy.									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.			DUE TO, OR AS A CONSEQUENCE OF (b) I diopathic/Advanced age.									
			DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Chronic renal failure.												
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from Nov. 19 79, to 12/9 1985, that (I) (we) last saw the deceased alive on 11/25 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												
22b. SIGNATURE Jonathan Maltz		22c. DEGREE MD.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 12/9/85						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JONATHAN MALTZ		22e. ADDRESS 18111 PRINCE PHILIP DR, OLNEY, MD 20832										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/10/85		23c. NAME OF CEMETERY OR CREMATORIAL Lee Crematory		23d. LOCATION CITY OR TOWN Washington, D.C.		23e. COUNTY		STATE		
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 New Hampshire Ave.						25a. DATE REC'D. BY REGISTRAR S.S. 1985		25b. REGISTRAR SIGNATURE Hines/Rinaldi				

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FUNERAL HOME NAME. PAGE 4 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1-2 SHOULD BE FILLED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												35235		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b HOUR 9:15 A.M.		
Clarence B. Nelson						<input checked="" type="checkbox"/> <input type="checkbox"/>			12	26	85			
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	7 IF UNDER 1 YR.	8 IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d HOUR 9:15 A.M.		
Male	Caucasian	June 6, 1907	78 yrs	MONTHS	DAYS	HOURS	MIN	12			26	85		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
New York			United States						Montgomery County,					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
Rockville			2414 Stratton Drive			Salesman			IBM					
13a STATE New York			13b COUNTY Monroe			13c CITY OR TOWN Rochester			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 45 Greenbriar Drive 14624		
14. FATHER'S NAME FIRST Frederick			MIDDLE Nelson			15. MOTHER'S MAIDEN NAME FIRST Nina			MIDDLE B.			LAST Holmes		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT Wife Lucille J. Nelson same as 13			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No			073-03-7810											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <i>Cardio Respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u>														
{ (b) <i>Coronary arterio sclerosis.</i> DUE TO, OR AS A CONSEQUENCE OF														
(c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?								
									YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>John F. Tauber</i>			TITLE (SPECIFY) M.D. <i>Death</i>			MEDICAL EXAMINER			DATE SIGNED December 26 1985					
EXAMINER'S NAME (TYPE OR PRINT)			John F. Tauber, M.D.			ADDRESS 8218 Wisc. Ave. Bethesda, Md. 20814								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Dec. 30, 1985			23c. NAME OF CEMETERY OR CREMATORIUM Holy Ghost Cemetery			23d. LOCATION CITY OR TOWN Gates			COUNTY STATE New York		
Burial														
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A.						25a. DATE REC'D. BY REGISTRAR DFO 27 1985			25b. REGISTRAR'S SIGNATURE <i>John F. Tauber Pendleton</i>					
300 W. Montgomery Ave. Rockville, Maryland														



364019

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 65 35234

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST PAULINE	MIDDLE E	LAST NENNO	2a. DATE OF DEATH 12-14-85	MONTH 12	DAY 14	YEAR 85	2b. HOURS 7 <sup>14</sup> PM		
3. SEX Female		4. RACE White	5. DATE OF BIRTH July 30 1891			6. AGE (IN YEARS LAST BIRTHDAY) 94			IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home				
13a. STATE None		13b. COUNTY None		13c. CITY OR TOWN Washington D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2450 Virginia Ave. # E616 (20037)				
14. FATHER'S NAME FIRST William		MIDDLE -		LAST Ronolder		15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE -			LAST Vossler	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. --		17. INFORMANT Daughter		ADDRESS Mary K Nenno			Same as # 13 above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ACUTE Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs 3 years												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) <input type="checkbox"/> attended the deceased from <i>Nov 19 82</i> to <i>Dec 14 85</i> , that (I) <input type="checkbox"/> last saw the deceased alive on <i>Dec 14 1985</i> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.												
22b. SIGNATURE <i>James Foster MD</i>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/15/85</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James V. Foster</i>		22e. ADDRESS <i>916 19th N.W. Wash.</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Dec. 18, 1985		23c. NAME OF CEMETERY OR CREMATORIAL St. Boneventure Cem		23d. LOCATION CITY OR TOWN Allegany		COUNTY			STATE New York	
24. FUNERAL DIRECTOR NAME <i>Robert A. DeVol</i>		ADDRESS DeVol Funeral Home 2222 Wisc. Ave Washington D.C.		25a. DATE REC'D. BY REGISTRAR DEC 18 1985		25b. REGISTRAR'S SIGNATURE <i>Juliann [Signature]</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please send this paper to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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DHMH - 10-60M 7/84  
(VRA 15, 4)

NAME OR TITLE

Mr. J. U.

DESCRIPTION

MR

J. U.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 35235

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Rosalind S Ney						December 26, 1985				5:45 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Female		White		Month Day Year Feb. 17 1924		61		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Penns.		U.S.A.				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda		5915 Mass. Ave.		Homemaker		Home					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						999999					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		4106-42nd St., N.W. 20016	
Wash. D.C.				Wash. D.C.							
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Bert				Sarazan		Elfreda				Wechsler	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		577-30-1249		Milton R Ney, Jr.		Same as item 13.		5 minutes			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest											
DUE TO, OR AS A CONSEQUENCE OF (b) coronary Artery Heart Disease 12 years											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerosis 15 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (he/she) attended the deceased from 19 65 to December 26, 19 85, that (I) lost saw the deceased alive on December 15, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (he/she) did (not) view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
Frederick Meyers, M.D.								12/26/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				6860 Tulip Hill Terrace				Bethesda, Maryland 20816	
Frederick Meyers, M.D.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN Suitland		COUNTY Maryland		STATE	
Cremation		12/27/85		Cedar Hill Crematory							
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisc Ave., N.W. Wash., D.C.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
		JAN 6 1986		Julie Tisdale Pendell							

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed, it should be retained for use as the burial permit with the State Dept. of Health and Mental Hygiene prior to burial or removal. (IMPORTANT: If item 21 is marked as item 18 shows any injury, a more traumatic event, the medical examiner must be notified at once.)

John Talbot, M.D. certified and signed my copy of this certificate. BP  
DHMH - 16:60M 7/84  
(VRA 15, 4)John Talbot, M.D. certified and signed my copy of this certificate. BP  
Division of Vital Records, 201 W. Preston St., Baltimore, Maryland 21201

• In Figure 1, the left-hand procedure will yield results which may not  
• be as good as the right-hand procedure,  
• but they will be more rapid.

345148

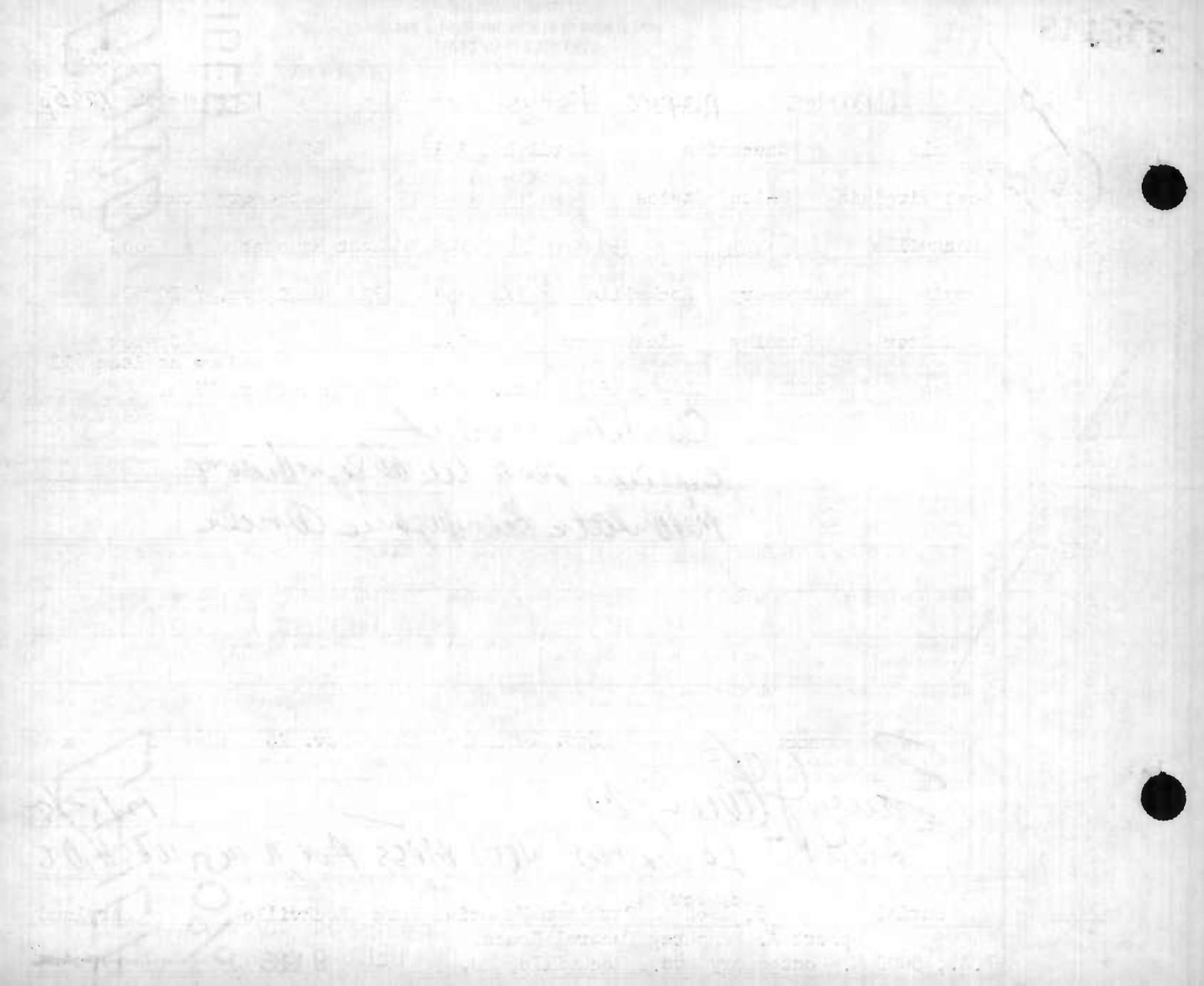
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
REG. NO. _____													
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Charles Sperow Nicewarner						12 - 4 - 85						1235 p.m.	
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male Caucasian			United States		April 10, 1919			66 yrs.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
West Virginia			United States					Montgomery County, MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Rockville			Shady Grove Adventist Hospital			Meat Manager			Food				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 719 Beall Ave. / 20850			
Maryland			Montgomery		Rockville								
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST				
Walter			Stanley	Nicewarner	Nelle								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			Same as item #13		
Yes WWII			218-03-1653		Mrs. Alice May Nicewarner, Wife,								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
18b. DUE TO, OR AS A CONSEQUENCE OF <i>superior vena caval syndrome</i>													
18c. DUE TO, OR AS A CONSEQUENCE OF <i>metastatic bronchogenic cancer</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)					
22a. I certify that (1) <input checked="" type="checkbox"/> attended the deceased from Nov. 14, 1985, to Nov. 26, 1985, that (1) <input type="checkbox"/> lost saw the deceased alive at Nov. 26, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Sayre Hellen M.D.</i>			22c. DEGREE					22d. DATE SIGNED <i>12/15/85</i>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>1341224 J. Levin, M.D.</i>			22f. ADDRESS <i>4601 MASS Ave NW - WAS H.D.C.</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE December 7, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Memorial Park			23d. LOCATION CITY OR TOWN Rockville			COUNTY Maryland	
Burial													
24. FUNERAL DIRECTOR NAME P.A., 3003 W. Montgomery Ave., Rockville, MD.						25a. DATE REC'D. BY REGISTRAR DEC 9 1985			25b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>				



357050

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, AND 1 TO THE FUNERAL DIRECTOR.

PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

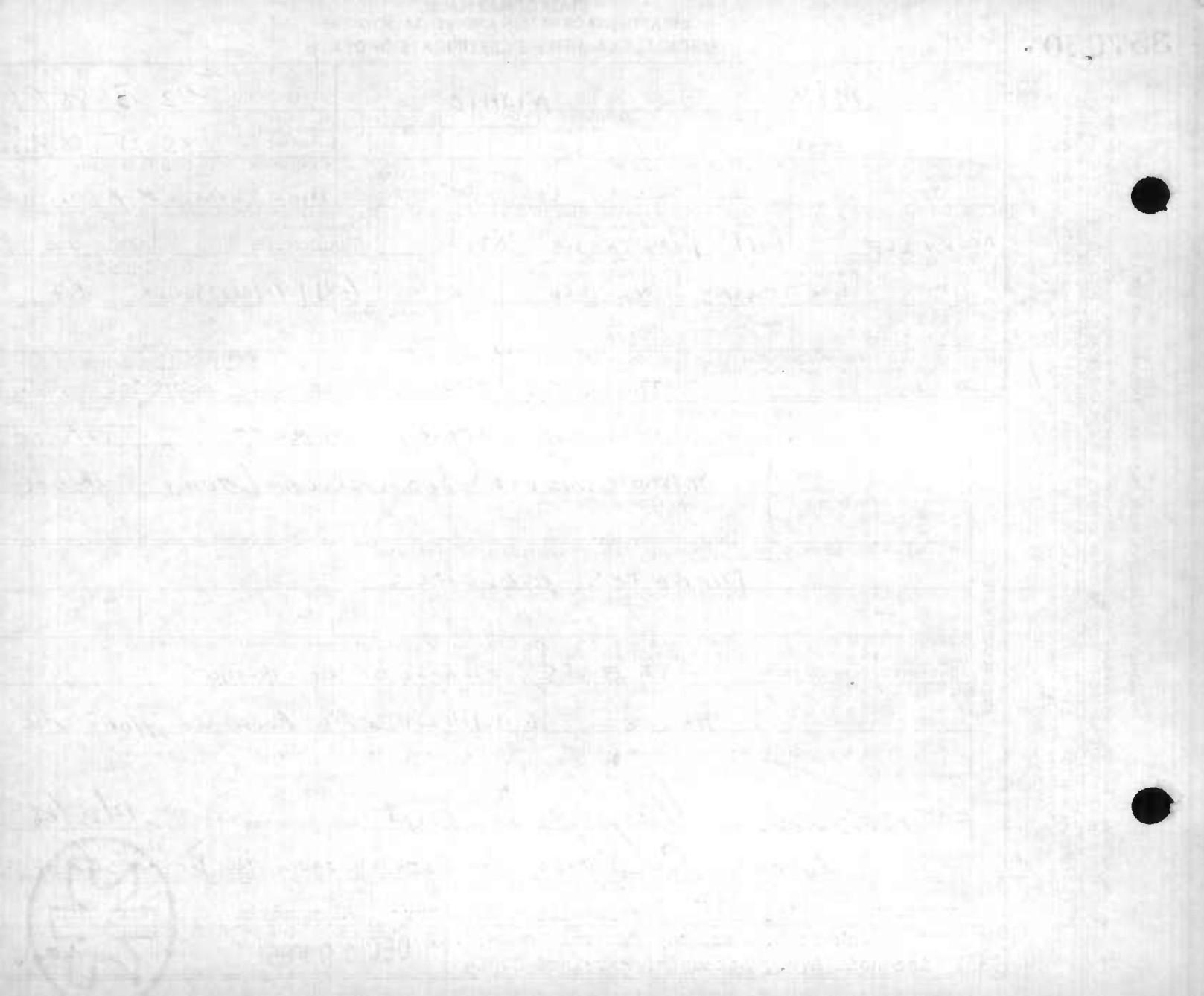
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

35231

REG. NO.

1-  
FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF EST. DEATH MATED	MONTH	DAY	YEAR	2b. HOUR	
<i>Miyo</i>					<i>NISHIO</i>	12	13	1985	PM		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Female	Oriental	May 28, 1898	87 yrs.	MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED	NEVER MARRIED	WIDOWED	4. DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH			
Japan		United States		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<i>MONTGOMERY Co., MD.</i>			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Rockville		6111 Montrose Rd				Housewife				Own Home	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS	20852			
MD	Montgomery	Rockville					6111 Montrose Rd				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST				MIDDLE	LAST		
Hatsujiro			Yoshida	Toyo					Oshima		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT				Daughter 7020 Sulky Lane			
No		577-84-3637		Seiko N. Wakabayashi				Rockville, Md. 20852			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>CARDIOPULMONARY ARREST</i>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.											
(b) <i>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</i>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
ACUTE											
INDOF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
12/13/85		DIABETES MELLITUS				<input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		20. AUTOPSY?					
		P.M. 12 13 1985		COLLAPSED AT HOME		<input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN					
		Home		STREET		CITY OR TOWN					
						COUNTY					
						STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
TITLE (SPECIFY) <i>Francis G. Mayle, M.D.</i> Dept. MEDICAL EXAMINER											
DATE SIGNED <i>12/15/85</i>											
EXAMINER'S NAME (TYPE OR PRINT) <i>Francis G. Mayle</i> ADDRESS <i>8200 Wisconsin Ave Bethesda MD 20814</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Cremation		Dec. 16, 1985		Metropolitan Crematory		Alexandria		Virginia			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Robert A. Pumphrey Funeral Homes, P.A.				DEC 19 1985				<i>Robert A. Pumphrey</i>			
7557 Wisconsin Ave., Bethesda, Maryland 20814											



347083

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8535238

1 - STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
<i>Martin</i>			<i>Percy</i>	<i>Norman</i>		<i>12-4-85</i>				<i>4-AM</i>		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.		
<i>Male</i>		<i>White</i>		MONTH	DAY	YEAR	<i>61</i>	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
<i>Pennsylvania</i>		<i>U.S.A.</i>						<i>Montgomery County, MD.</i>				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
<i>Silver Spring</i>		<i>Holy Cross Hospital</i>		<i>Manufac. Rep.</i>		<i>Liquor Industry</i>						
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13e. STREET ADDRESS / ZIP CODE									
<i>Maryland</i>	<i>Montgomery</i>	<i>Silver Spring</i>	<i>(20910)</i> <i>2445 Lyttonsville Road, #816</i>									
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
<i>Benjamin</i>			<i>Rose</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
<i>Yes</i>			<i>WWII</i>			<i>Sylvia Norman; Wife: 2445 Lyttonsville Rd., #816</i>			<i>Silver Spring, Md. 20910</i>			
18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR 18, 19, 20 AND 21) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (18)			cardiac arrest (ventricular fibrillation)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
									<i>6 hrs</i>			
Conditions, if any, which gave rise to immediate cause (18), stating the underlying cause lost.			(b) severe cachexia of cancer						3 weeks			
			(c) cancer of stomach						3 years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>12/3</i> , 19 <i>85</i> , to <i>12/14</i> , 19 <i>85</i> , that (I) (we) lost sow the deceased alive on <i>12/14</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and on the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Bruce A. Silver, M.D.</i>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/4/85</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Bruce A. SILVER, M.D.</i>		22e. ADDRESS <i>106 Irving St., N.W., Washington, DC 20010</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>12/5/85</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Judean Memorial Gardens Olney; Montgomery; Maryland</i>		23d. LOCATION CITY OR TOWN <i>Olney</i>		23e. COUNTY <i>Montgomery</i>			23f. STATE <i>Maryland</i>	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852		<i>DEC 9 1985</i>		<i>Julia L. Dearden, Director</i>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Failure to do so may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, remove carbon paper. Please print legibly. This form should be detached for use as the funeral director's stamp. Then please return carbon paper to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Geology



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 5 2 3 7

346033

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME      FIRST      MIDDLE      LAST				2a. DATE OF DEATH      MONTH      DAY      YEAR	2b. HOUR				
Grace      Oliver				December      2, 1985	1:30 AM				
3 SEX      4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR			
Female      White		MONTH      DAY      YEAR		88		IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 YRS.			
West Virginia		USA		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (IF NO WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Rockville		Randolph Hill's Nursing Home		Nurse Maid		Private			
13. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
None		None		Washington, DC		14. STREET ADDRESS / ZIP CODE 4224 45th St., NW 99999			
14. FATHER'S NAME      FIRST      MIDDLE      LAST				15. MOTHER'S MAIDEN NAME      FIRST      MIDDLE      LAST					
George Oliver				Alzada Williamson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS Washington, DC			
No		578 36 9479		Ethel M. Oliver, Sister, 4224 45th St., NW,		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA OF COLON</u>									
DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____  DUE TO, OR AS A CONSEQUENCE OF  (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED  <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>OCT 1, 1985</u> , to <u>DEC 2, 1985</u> , that (I) (we) last saw the deceased alive on <u>DEC 2, 1985</u> , and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.								22b. SIGNATURE <u>MARTIN C. SHARGEL</u>	
22c. DEGREE M.D.		ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 12/2/85					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MARTIN C. SHARGEL</u>		22f. ADDRESS 3720 FALLAGER AVE KENSINGTON, MD 20895		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 4, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet	
23d. LOCATION CITY/TOWN Washington, DC		23e. COUNTY COUNTY		23f. STATE STATE		25a. DATE REC'D. BY REGISTRAR NOV 6 1985		25b. REGISTRAR'S SIGNATURE <u>J. Shargel</u>	
24. FUNERAL DIRECTOR Detol Funeral Home, Inc. 222 Wisconsin Ave., NW, Washington, DC								25c. DATE REC'D. BY REGISTRAR NOV 6 1985	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. This page remains on the death certificate until 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, air removal.  
 IMPORTANT: If item 2 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be consulted before the death certificate is signed.

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DHMH - 16 60M 7/B4  
(VRA 15, 4)

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*and I am not afraid to do it.*

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Digitized by srujanika@gmail.com

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or attending physician. Then place in the burial permit. Then place in the casket papers. Page 1 and 2 should be filled in before removal.

with the State Dept. of Health and Mental Hygiene prior to burial. In the event of removal, the medical examiner.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
REG. NO. 85 352122													
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR		
WILLIAM MORRIS OLIVER						DECEMBER 10 1985					1014 AM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			2b. HOUR			
MALE		CAUCASIAN		MONTH NOV DAY 29 YEAR 1937			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
KENTUCKY		UNITED STATES					MONTGOMERY MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
BETHESDA		NAVAL HOSPITAL		U.S. NAVY			ARMED FORCES						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE FLORIDA		13b. COUNTY CLAY		13c. CITY OR TOWN ORANGE PARK			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1308 ELK CT. 32073			
14. FATHER'S NAME FIRST CLYDE		MIDDLE MNM		LAST OLIVER			15. MOTHER'S MAIDEN NAME FIRST MARGARET			MIDDLE MNM LAST RICE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. YES 1958-1985			17. INFORMANT			13758 MAPLEDALE AVE. WILLIAM MARTIN OLIVER, DALE CITY, VA 22193			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLUS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MENINGIOMA													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3 December 1985 to 10 December 1985, that (I) (we) last saw the deceased alive on 10 December 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>M. R. Ambrose</i>		22c. DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED 11 Dec 85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. R. AMBROSE, LCDR, MC, USN		22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MARYLAND 20814-5011											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 12 - 13-85		23c. NAME OF CEMETERY OR CREMATORIAL CHANAY FUNERAL HOME			23d. LOCATION CITY OR TOWN Hickman			COUNTY Kentucky STATE			
24. FUNERAL DIRECTOR NAME Marshall's Funeral Home ADDRESS 4217 9th St NW Washington, D.C. 20011		25a. DATE REC'D. BY REGISTRAR DEC 16 1985		25b. REGISTRAR'S SIGNATURE <i>J. L. K. Johnson</i>									

SC 1806



246-00-0001

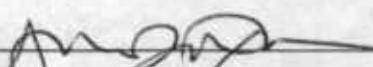
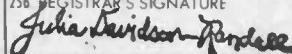
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**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 5A. PAGE 5 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH3524  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b HOUR				
			MARY	ANN	ONDREJKO	<input checked="" type="checkbox"/>	12	24	1985	M				
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS	MONTHS	DAYS	HOURS	MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d HOUR
Female	White	Aug. 25, 1940	45 yrs.							12	24	1985	7:40 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Virginia		U.S.A.					Montgomery County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring		Holy Cross Hospital			Bookkeeper/Account.		Nat'l Trading							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS						
Maryland		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1500 Hanby Street						
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		16. ADDRESS						
Lacey		O.		Roland		Mary		V. Garten						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ Cerebral hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
no		226-58-3127		Albert C. Ondrejko-1500 Hanby St. S.S., Md.										
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		{		(b) _____ DUE TO, OR AS A CONSEQUENCE OF										
		{		(c) _____ DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? HEAD ONLY <input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										Head Only Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion				
ACTUAL SIGNATURE 										TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., MD 21201								DATE SIGNED 12-25-85				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 12-28-85		23c. NAME OF CEMETERY OR CREMATORIAL National Memorial Park		23d. LOCATION CITY OR TOWN Falls Church, Va.		COUNTY		STATE				
Burial														
24. FUNERAL DIRECTOR NAME		Everly-Wheatley		Alexandria, Virginia		25a. DATE RECEIVED BY REGISTRAR DEC 31 1985		25b. REGISTRAR'S SIGNATURE 						
Funeral Home														

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME <i>Wilmer Wilmer</i>		FIRST	MIDDLE	LAST	2a DATE OF DEATH <i>12/29/85</i>	MONTH	DAY	YEAR	2b HOUR <i>2:10 A.M.</i>				
1. SEX <b>Male</b>		4 RACE <b>White</b>	5. DATE OF BIRTH <b>11/12/94</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			7c MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY County MD.</b>					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) <b>HOLY CROSS Hospital</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Auto Mechanic</b>			12b KIND OF BUSINESS OR INDUSTRY					
13. RESIDENCE (IF NURSING HOME, INDICATE LOCATION GIVE RESIDENCE BEFORE ADMISSION) <b>Maryland Montgomery</b>		13c CITY OR TOWN <b>Hyattsville</b>			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS / ZIP CODE <b>5506 39th Ave. 20781</b>					
14. FATHER'S NAME <b>Not Known</b>		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME <b>Not Known</b>									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>212-09-4150</b>			17. INFORMANT <b>Hyattsville Md. 20781</b>								
					<b>Florence S. Orpwood 5506 39th Ave.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18b DUE TO, OR AS A CONSEQUENCE OF <b>Auto Cardiopulmonary Arrest</b>			18c APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12/29/85</b>								
		(b) <b>Auto Aspiration Pneumonia</b>			18d DUE TO, OR AS A CONSEQUENCE OF <b>Chronic Renal Failure</b>					18e APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12/85</b>			
		(c) <b>Dehydration, ASCVD, Subacute Cerevascular, CVA</b>											
19a MEDICAL CERTIFICATION		19b DATE OF OPERATION <b>N/A</b>			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <b>N/A</b>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
		22a. I certify that <input checked="" type="checkbox"/> (the hospital) attended the deceased from <b>12/29/85</b> , 19_____, to <b>12/29/85</b> , 19_____, that <input checked="" type="checkbox"/> (two last) saw the deceased alive on <b>12/29/85</b> , 19_____, and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (I did not) view the body after death.											
		22b. SIGNATURE <b>G B Patrick III MD</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED <b>12/29/85</b>		
		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G B Patrick III MD</b>			22e. ADDRESS <b>1221 Colersville Rd Silver Spring, MD 20910</b>								
BP _____		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec 31 1985</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b>		COUNTY	STATE	<b>Maryland</b>	
DHMH - 16 60M 7/84 (VRA 15, 4)		24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b>		ADDRESS <b>Baltimore, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 30 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Linda Henderson Pendleton</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the doctor retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remain with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified during hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 35 35 240			
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Augusta H. Owens						12 10 85			M	
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 18 YEARS		8. IF UNDER 24 HRS	
Female		Black		Jan. 12, 1900			85			MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
MD		USA					Montgomery						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital								Housewife			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
MD		Montg.		Gaithersburg			YES <input type="checkbox"/>			15 Ribbon Court/ 20878			
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
Andrew Barnes							Estelle Ewell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH			
No		213-74-8230		Ernest S. Owens (son)			6101 16th St., NW Washington, DC 20011			12/10/85			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1983 to 19, that (I) (we) last saw the deceased alive on 11/30/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE 		22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 12/10/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		DR. OSOTH LEKAGUL			22e. ADDRESS 4425 ARLINGTON RD, BETHESDA, MD 20814								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		12-14-85		Mt Zion Cemetery			Sellman, Montg.		MD				
24. FUNERAL DIRECTOR NAME		246 N. Washington St. Rockville, MD 20850			25a. DATE REC'D. BY REGISTRAR DEC 18 1985			25b. REGISTRAR'S SIGNATURE 					
George R. Snowden													

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REG. NO.

TO HOSPITAL OR ABOARDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies 1 and 2 should be left within 72 hours after death  
**BY**

IMPORTANT

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE CORBLY PAFFENBARGER</b>			2a DATE OF DEATH MONTH DAY YEAR <b>DECEMBER 15 1985</b>	2b HOUR <b>12:57 a</b>
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>NOVEMBER 3 1902</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>OHIO</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b>	MD.
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. STREET ADDRESS / ZIP CODE <b>407 RUSSELL AVE 20877</b>	
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>GAITHERSBURG</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. ADDRESS
14. FATHER'S NAME FIRST MIDDLE LAST <b>ANDREW WOLFE PAFFENBARGER</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA PRISCILLA SEAL</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1941-1967</b>	16c. INFORMANT <b>RACHEL A. PAFFENBARGER, 407 RUSSELL AVE., #804</b>	16d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA OF THE PROSTATE</b>				
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____				
DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-a				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>DECEMBER 5, 1985</b> , to <b>DECEMBER 15, 1985</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (not) (if applicable) view the body after death.				
22b. SIGNATURE <i>J. H. Edmunds</i>	22c. DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED <b>17 Dec 85</b>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. H. EDMUNDS, LCDR, MC, USN</b>	22f. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>12/17/85</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Lee's Crematory</b>	23d. LOCATION CITY OR TOWN <b>Washington, D. C.</b>	23e. COUNTY STATE
24. FUNERAL DIRECTOR NAME <b>Gartner Sandison F. H. Gaithersburg, Md. 20877</b>	25a. ADDRESS <b>316 E. Diamond Ave.,</b>	25b. DATE REC'D. BY REGISTRAR <b>EL 20</b>	25c. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

RECORDED  
IN COLOR



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FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 3 5 2 4 5

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
<b>HELEN AZUKAS PARIS</b>						<b>12-13-85</b>				<b>2:29 PM</b>				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
<b>Female</b>		<b>Cauc</b>		MONTH	4	DAY	<b>-27</b>	YEAR	<b>75</b>	YRS.	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery CTY</b> MD.								
Scranton, PA		<b>United States</b>												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
<b>Almont Park</b>		<b>Washington Adventist Hosp</b>		<b>Homemaker</b>		<b>at home</b>								
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Prince George</b>		13c. CITY OR TOWN <b>Takoma Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>901-Larch Avenue 20910</b>						
14. FATHER'S NAME FIRST <b>Peter</b>		MIDDLE <b>Michael</b>		LAST <b>Azukas</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Ellen</b>		MIDDLE -		LAST <b>Kapchunas</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS								
<b>No</b>		<b>215-48-1068</b>		<b>David B. Paris (son)</b>		<b>Same as 13</b>								
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRAIN DEATH</b>														
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Anoxic Encephalopathy</b>														
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Paralysis of diaphragm (R1)</b>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>12-9-1985</b> , to <b>12-13-1985</b> , that (I) (we) last saw the deceased alive on <b>12-13-1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <b>Tony P. Kannarkatt</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>12/13/85</b>								
22d. PHYSICIAN'S NAME, (TYPE OR PRINT) <b>TONY P. KANNARKATT. MD</b>		22e. ADDRESS <b>8201 16<sup>th</sup> ST S-S. MD 20910</b>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Dec. 14, 1985</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Lee's Crematory</b>		23d. LOCATION CITY OR TOWN <b>Washington, District of Columbia</b>		CITY OR TOWN COUNTY STATE						
24. FUNERAL DIRECTOR <b>J.Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 17 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John Wm. Lee</b>										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please return page 2 to the funeral director. If page 2 is not returned, it will be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or items 22b, 22c, 22d, 22e, 23d, 24, 25a, 25b are marked or checked, the medical examiner must be notified.

Cleared by Medical Examiner (Dr. Rocks) 12/13/85

Q.W.W. Tee, e. Gomes Co. 300-448 St., W.H. Mass., DC500CS  
Sherman's Ferry Dec. 14, 1982 Rec'd, e. Sherman Ferry  
Massachusetts' District of Columbia

No STP-48-1008 Davy P. Lantz (son) same as 13

Letter Migelet Ankaas Effler - Kslchunusse

Marjaford Prince George Skowes Park x 800~~45~~  
Mallory Avenue

at home Homeowner

Scarsborough, PA United States x

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

6 5 3 5 2 4 6

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>William</i>					<i>Parker</i>	<i>12-16-85</i>				<i>8:40 AM</i>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
<i>Male</i>		<i>Black</i>		MONTH	DAY	86	YRS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
<i>New York</i>		<i>U.S.A.</i>						<i>Montgomery</i>			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13a. STREET ADDRESS / ZIP CODE		12b. KIND OF BUSINESS OR INDUSTRY			
<i>Takoma Park</i>		<i>Washington Adventist Hospital</i>				<i>2100 Brooks Drive #218</i>		<i>Self-employed</i>			
13. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS / ZIP CODE		14. FATHER'S NAME			
<i>Maryland</i>		<i>Pr. Geo.</i>	<i>Forestville</i>			<i>20747</i>		<i>First</i>	<i>Middle</i>	<i>Last</i>	
								<i>William</i>	<i>W</i>	<i>Parker, Sr.</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS		15. MOTHER'S MAIDEN NAME			
<i>No</i>		<i>097-10-8844</i>		<i>Louise Parker</i>		<i>Forestville, Md.</i>		<i>Mattie</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
								<i>Ventricular tachycardia</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		<i>Coronary artery disease</i>		<i>years</i>					
		(c)		<i>Gen A50</i>		<i>years</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
<i>11-29-85</i>		<i>Pulmonary Bronchoscopy</i>		<input type="checkbox"/> NO <input checked="" type="checkbox"/> YES		<input type="checkbox"/> NO <input checked="" type="checkbox"/> YES					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22. I certify that (I) (this hospital) attended the deceased from <i>11-25-85</i> to <i>12-16-85</i> , that (I) (we) last saw the deceased alive on <i>12-16-85</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
23. PHYSICIAN'S NAME (TYPE OR PRINT)		24. DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED	
<i>KENNETH CRUZE</i>										<i>12/16/85</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORI		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
<i>Cremation</i>		<i>12-18-85</i>		<i>Cedar Hill Crematory</i>		<i>Suitland, Maryland</i>					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<i>COLUMBIA Mortuary Services</i>		<i>225 Missouri Ave NW, Wash., D.C.</i>		<i>DEC 23 1985</i>		<i>Julie Davidson-Randall</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be forwarded to the funeral director. Page 2 should be attached to item 2a as the burial permit. Then please remove carbon copies. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene, p.o. Box 1200, Annapolis, Maryland 20702.

IMPORTANT: If item 2b is marked on item 18 shows any injury or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or either traumatic or nontraumatic, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												5 3 5 2 4 1			
												REG. NO.			
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			<i>MARY L. PARMENTIER</i>						<i>12 24 85</i>			<i>5 50 AM.M</i>			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			2b. HOUR IF UNDER 24 HRS. HOURS MIN.			
<i>FEMALE</i>			<i>WHITE</i>			<i>01 02 91</i>			<i>94 YRS.</i>						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
<i>WASHINGTON, DC</i>			<i>U.S.</i>						<i>SILVER SPRING MD</i>			MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUPPLY FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
<i>Silver Spring Ind</i>			<i>BEL PRE HEALTH CARE CENTER</i>			<i>Measure Supports</i>			<i>Surgical</i>						
13a. STATE MD			13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 2601 Bel Pre Rd./20906			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
<i>Henry Francis Smith</i>			<i>Caroline Renault Crawford</i>												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
<i>No</i>			<i>578-01-7301</i>			<i>Helen S. Petitt</i>			<i>Chevy Chase, MD</i>						
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												<i>Cerebral Vascular accident</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												<i>4 days</i>			
(b) <i>Chronic Cardiovascular Nephritis</i>												<i>10 years</i>			
(c) <i>Sclerosis</i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <i>July 30 1985</i> to <i>31 Dec 1985</i> that (I) (we) last saw the deceased alive on <i>July 30 1985</i> and that in my (our) opinion death occurred on the date and hour and from the cause(s) stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Robert C. Haile M.D.</i>			22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS <i>5100 Wis. Ave., NW, Washington, D.C. 20016</i>			22e. DATE SIGNED <i>12/24/85</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>12/27/85</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Glenwood Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Washington, D.C.</i>			COUNTY STATE			
24. FUNERAL DIRECTOR NAME <i>Joseph Gawler's Sons, Inc.</i>			24b. ADDRESS <i>5130 Wisconsin Ave., NW, Washington, D.C. 20016</i>			25a. DATE REC'D. BY REGISTRAR <i>JAN 6 1986</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Dawson-Parks</i>						

factories, etc., around

are used for food

and health

industry. Many different kinds of

chemicals are used in the

manufacture of food products.

These chemicals are used to

make food more palatable, nutritious,

and attractive. Some of these chemicals

are safe, while others are not.

It is important to know what

chemicals are used in food products

and how they affect the body.

Some of these chemicals are

harmful to the body if taken in large

amounts. Others are safe if taken in

small amounts. It is important to know

which chemicals are safe and which are

not safe. This knowledge will help you

to make better choices about what you eat.

It is also important to know how much

of each chemical is safe to eat. This

information can be found in the

Food and Drug Administration's

002117

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

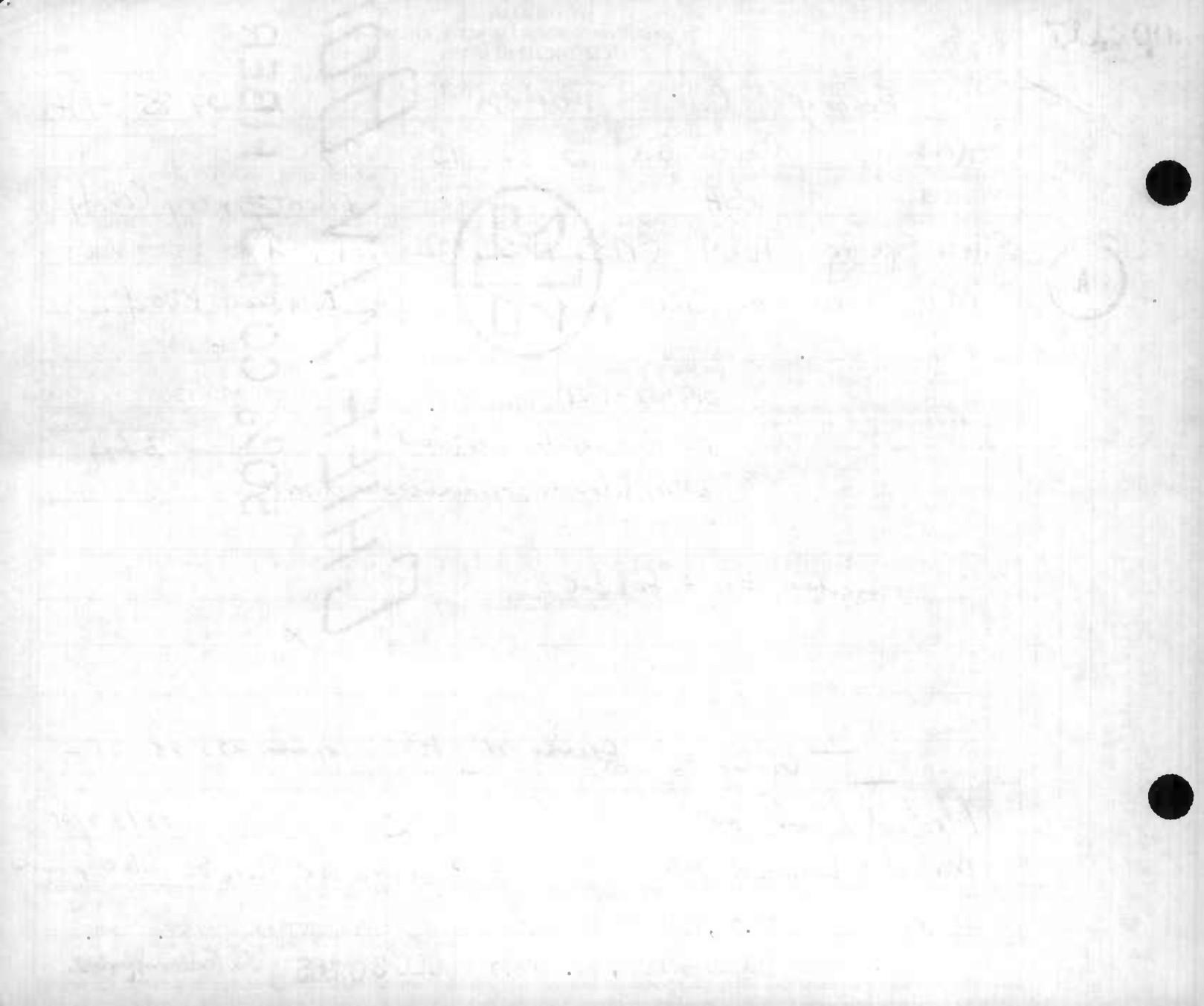
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8535245							
												REG. NO.							
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST Emory			MIDDLE C. C.			LAST Patton			2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
															12 27 85				4 A.M.
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS.				
MALE			Caucasian			MONTH 2 DAY 28 YEAR 12			73			MONTHS YRS			HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			10b. KIND OF BUSINESS OR INDUSTRY				
COUNTY VIRGINIA			USA						Montgomery County MD.			TURF FARMER			TURF FARMING				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Silver Spring			Holy Cross Hospital			13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d. STREET ADDRESS / ZIP CODE				
MD			Montgomery Silver Spring			13e. STATE			13f. CITY OR TOWN			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			701 Norwood Road 21901				
14. FATHER'S NAME FIRST JOHN			MIDDLE T.			LAST PATTON			15. MOTHER'S MAIDEN NAME FIRST LOLA			MIDDLE M.			LAST McKIMMEY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
NO			317-32-1921						Cerebrovascular accident						3 days				
									(b) arteriosclerotic cardiovascular disease										
									(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) congestive heart failure																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE				
22a. I certify that (I) (the hospital) attended the deceased from December 21, 1985, to December 27, 1985, that (I) (we) last saw the deceased alive on December 26, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			22b. SIGNATURE Michael Lincoln MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/27/85							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. Lincoln MD.			22e. ADDRESS 10313 George St Suite 308 Silver Spring MD																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE DEC. 30, 1985			23c. NAME OF CEMETERY OR CREMATORIAL COLESVILLE			23d. LOCATION CITY OR TOWN COLESVILLE			23e. COUNTY MONT.			STATE MD.				
24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20879			ADDRESS			25a. DATE REC'D. BY REGISTRAR DEC 30 1985			25b. REGISTRAR'S SIGNATURE Julia Davidson Pendle										

3  
filled in by funeral director. Page 3  
within 24 hours after death. Page 4 may be  
filled in by funeral director. Page 3  
within 72 hours after death.

DHMH - 16 60M 7/84  
(VRA 15, 4)



352093

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the Burial Transit Permit. Then please remove carbon paper. Pages 1 &amp; 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury other than a traumatic event, the medical examiner must be consulted at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 3 5 2 4 7			
										REG. NO.			
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2d. HOUR	
			Angela Susan Pedowitz						12 8 85			10 12 4 M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Caucasian		MONTH DAY YEAR			1 YRS			MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Washington, D.C.		United States		Suburban Hospital			Montgomery County MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN DOH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital								none		none	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Maryland		Montgomery		Chevy Chase		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4701 Willard Ave 20815					
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME			FIRSt MIDDLE LAST						
Robert Alan Pedowitz				TINA Marie Wortman									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS						
no		none		Robert A. Pedowitz see #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) RESPIRATORY ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) MUSCULAR DYSTROPHY													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
19a.					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED  WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 9/20/85 19 to 11/18/85 19, that (I) (we) last saw the deceased alive on 11/18/85 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death,													
22b. SIGNATURE Raymond H. COLEMAN										DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			22f. DATE SIGNED 12/18/85								
RAYMOND H. COLEMAN		11119 ROCKVILLE PIKE, ROCKVILLE MD 20852											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		Dec. 11, 1985		Ft. Lincoln Cemetery			Brentwood		Maryland				
24. FUNERAL DIRECTOR NAME P.A. 300 W. Montgomery Av., Rockville, Maryland		25a. DATE REC'D. BY REGISTRAR REC 16 1985			25b. REGISTRAR'S SIGNATURE debra								

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347016

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

85 35 250

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR	
<del>10</del> Wilbur T					Pentzer	12-09-85				3:15 PM	
1. SEX <input checked="" type="checkbox"/> Male		4. RACE White		5. DATE OF BIRTH Sept. 08 1901		6. AGE (IN YEARS LAST BIRTHDAY) 84		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE COUNTRY <input checked="" type="checkbox"/> Nebraska		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION Horticulturist		12b. KIND OF BUSINESS OR INDUSTRY Agriculture					
13. AL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 13216 Ingleside Drive Beltsville		20705	
14. FATHER'S NAME Albert		MIDDLE	Pentzer	15. MOTHER'S MAIDEN NAME Ina		16. SOCIAL SECURITY NO 215-44-7981		17. INFORMANT Mary M. Pentzer		ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (1a)		19. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (1a), stating the underlying cause last. (b)		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS							
		19. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) <input type="checkbox"/> attended the deceased from JULY 1985 to DECEMBER 9 1985, that (I) <input type="checkbox"/> lost saw the deceased alive on DECEMBER 9 1985, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did not view the body after death.											
22b. SIGNATURE James A. Brown MD		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 12/9/85					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) James A. Brown MD		22f. ADDRESS 4400 Physician Lane, Suite 232 Rockville Md 20850									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-10-85		23c. NAME OF CEMETERY OR CREMATORIAL Balt. Wash. Crematory		23d. LOCATION Laurel		COUNTY Prince George		STATE Md	
24. FUNERAL DIRECTOR Donald V. Borgward		4400 Powder Mill Road ADDRESS Beltsville, Md. 20705		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE BEG 11 1985 n. Mandella					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be retained for use in the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



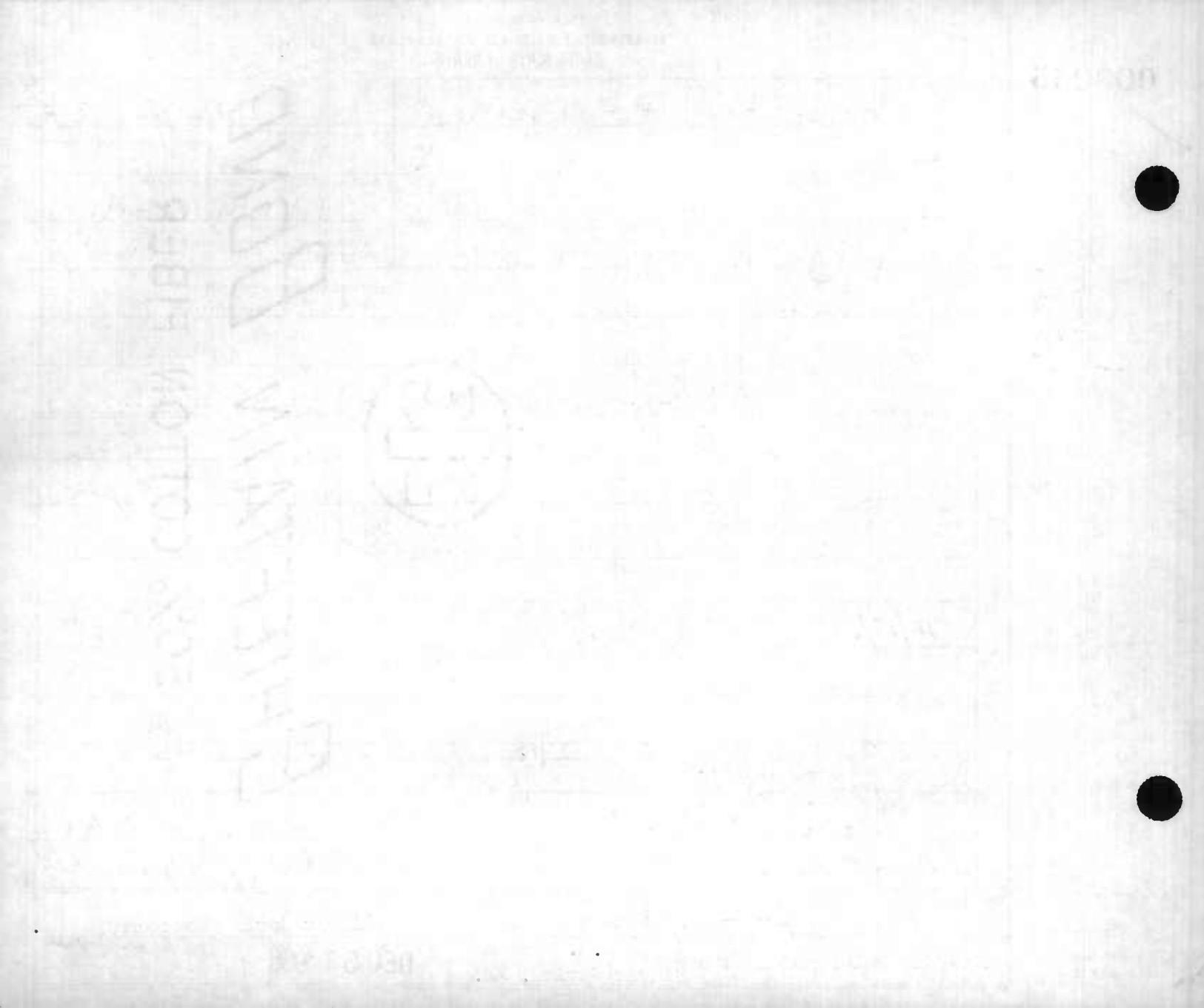
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached from the burial permit. Then please remove carbon paper. Please send a copy of the death certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 1B shows any injury or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 3525					
										REG. NO.					
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR <u>8 15</u> <u>AM</u>			
			<u>Margherita Petruccelli</u>						<u>12-26-85</u>						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MINUTES			
<u>F</u>		<u>W</u>		<u>7 10 120</u>			<u>73</u>								
7e. BIRTHPLACE COUNTRY		7f. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
<u>Italy</u>		<u>USA</u>					<u>Montgomery</u>			MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION 12b. TYPE OF WORK FOR MOST OF WORKING LIFE			12c. KIND OF BUSINESS OR INDUSTRY							
<u>Silver Spring</u>		<u>Holy Cross Hospital</u>			<u>Housewife</u>			<u>own home</u>							
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13e. CITY OR TOWN		13f. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13g. STREET ADDRESS / ZIP CODE			13h. ADDRESS					
13. STATE <u>Maryland</u>		13e. COUNTY <u>Montgomery</u>		13f. YES <input checked="" type="checkbox"/>			<u>4115 Sprull Drive</u>			<u>20895</u>					
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST						
<u>Paolo</u>				<u>Orazia</u>					<u>Verna</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <input type="checkbox"/> YES <input type="checkbox"/> NO		16b. SOCIAL SECURITY NO. <u>N/A</u>		17. INFORMANT <u>Lilia D'Avella-daughter-(same as 13e)</u>			ADDRESS								
18. CAUSE OF DEATH (Enter only one cause per line for 18a, b, and c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerevascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hr.</u>		
(c) <u>Urinary Cervical Bladder</u>													<u>3 yrs.</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION <u>12/19/85</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Abdominal procedure</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>12/25/85</u> to <u>12/26/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body, write "N/A")															
22b. SIGNATURE <u>Steven Cristina MD</u>					DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/26/85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Steven CRISTINA MD.</u>		22e. ADDRESS <u>344 University Blvd. Silver Spring Md.</u>													
23a. BURIAL, CREMATION, REMOVAL SPECIFY <u>Burial</u>		23b. DATE <u>12-30-1985</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>			23d. LOCATION CITY OR TOWN <u>Silver Spring</u>			COUNTY		STATE			
24. FUNERAL DIRECTOR <u>Hines/Rinaldi Funeral Home</u>		25a. ADDRESS <u>11800 N.H. Avenue</u>			25b. DATE REC'D. BY REGISTRAR <u>DEC 31 1985</u>			25b. REGISTRAR'S SIGNATURE <u>John Rinaldi</u>							
BP _____		Silver Spring, Md.													
DHMH - 16 60M 7/84 (VRA 15, 4)															



353297

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
LEAH KATHERINE PETT						DECEMBER 4 1985				9:50 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		CAUCASIAN		JUNE 15 1949		36		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
TENNESSEE		UNITED STATES								MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		NAVAL HOSPITAL				LIBRARIAN				99999 22031	
13a. STATE VIRGINIA		13b. COUNTY FAIRFAX		13c. CITY OR TOWN FAIRFAX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3051 MISSION SQUARE DRIVE			
14. FATHER'S NAME FIRST RAYMOND ZIELINSKI		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST DOROTHY LYONS		MIDDLE		LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) YES 1969-1972		17. INFORMANT		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		RESPIRATORY FAILURE								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) PLEURAL EFFUSION									
		(c) BREAST CARCINOMA									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 29 1985 to DECEMBER 4 1985, that (I) (we) last saw the deceased alive on DECEMBER 4 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did/did not view the body after death.											
22b. SIGNATURE 		22c. DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22d. DATE SIGNED 5 Dec 85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. H. EDMUNDSEN, LCDR, MC, USN		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION BETHESDA, MD 20814									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/5/1985		23c. NAME OF CEMETERY OR CREMATORIAL Lee Crematory		23d. LOCATION CITY OR TOWN Washington D.C.		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Colonial Funeral Home Falls Church Va		25a. DATE REC'D. BY REGISTRAR DEC 10 1985				25b. REGISTRAR'S SIGNATURE 					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be continued on reverse side and completely filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please return to medical examiner. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGES 3 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED OUT IN PEN IN INK. PRIEST TO PASTOR, PRIEST TO PRIEST, ETC.

AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												3 5 2 5 3			
												REG. NO.			
1- STATE REGISTRAR			DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR MONTH DAY YEAR			
Erin Elizabeth Mindick Phillips									<input checked="" type="checkbox"/> 12-4 19						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR MONTH DAY YEAR	
Female		Cauc.		Dec. 31, 1984		YRS.		11 3				12-4 1985		10:05 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland			United States						WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Montgomery County, MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY
Rockville			Shady Grove Hospital									None			N/A
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Gaithersburg			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 8311 Fairhaven Drive/20877				
14. FATHER'S NAME First Middle Last			Burl J. Mindick Phillips			15. MOTHER'S MAIDEN NAME First Middle Last			Tammy L. Mindick						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. No 213-08-0534			17. INFORMANT ADDRESS			Burl J. Mindick Phillips, same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held an death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Dennis F. Smyth, M.D.												Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
TITLE (SPECIFY) Assistant MEDICAL EXAMINER												DATE SIGNED 12-5-85			
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn St., Balto., Md. 21201												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Dec. 6, 1985			23c. NAME OF CEMETERY OR CREMATORY Burial Parklawn Mem. Park			23d. LOCATION CITY OR TOWN Rockville, Maryland						
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes ADDRESS 300 West Montgomery Ave. Rockville, MD PA						25a. DATE REC'D. BY REGISTRAR DEC 9 1985			25b. REGISTRAR'S SIGNATURE Dwight D. Eisenhower						
DHMH - 17 (VR A15 ME (5))															



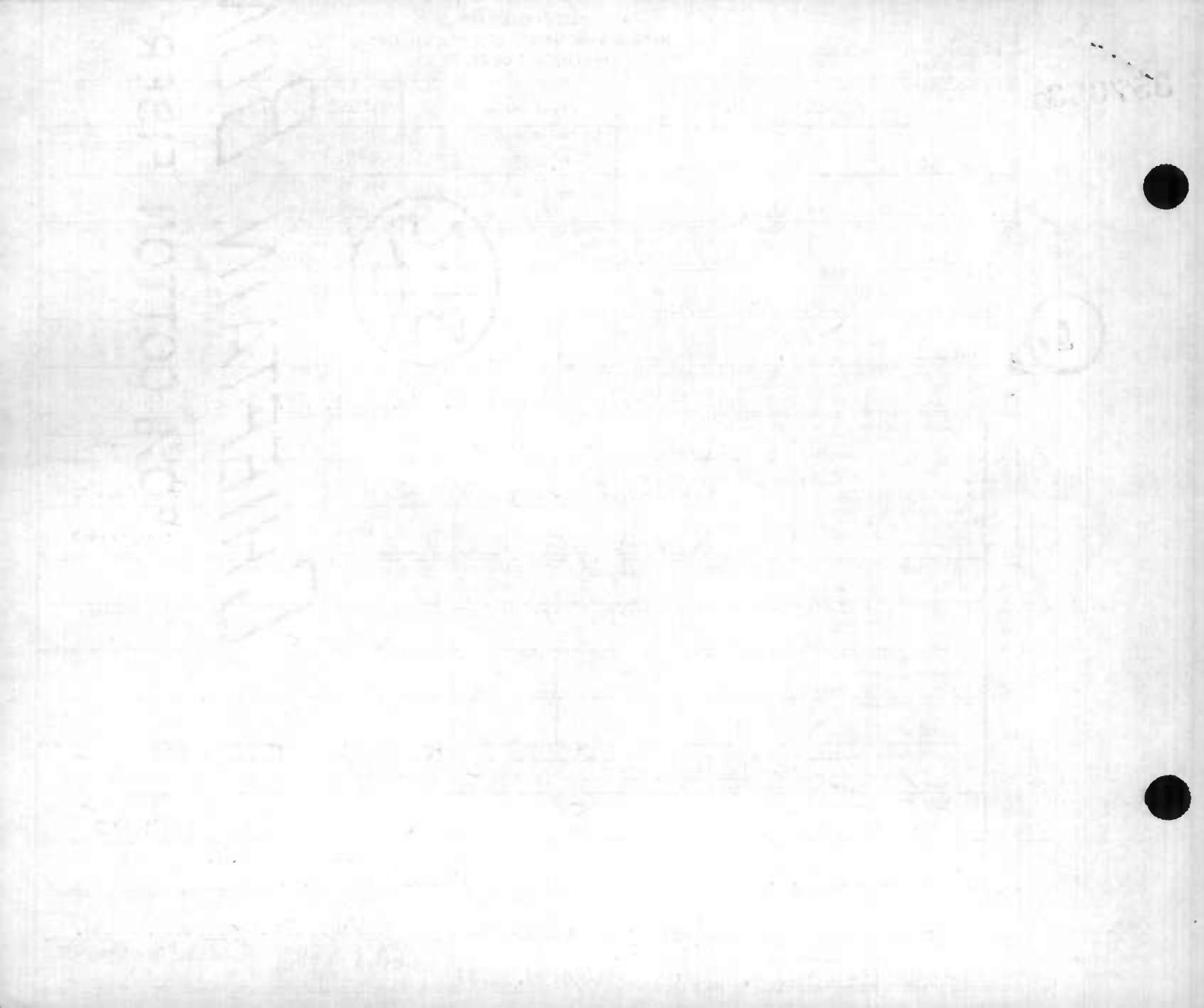
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pugs. (and 2 should be filled within 72 hours after death)

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 35 35 25 4			
1 - STATE REGISTRAR <i>357063</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>December 14, 1985</i>									2b. HOUR <i>7:50 P.M.</i>			
J. DECEASED NAME (TYPE OR PRINT) <i>Marie B. Phillips</i>			MIDDLE <i>B.</i>			LAST <i>Phillips</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>92</i>			IF UNDER 1 YEAR <i>YRS</i>			
3. SEX <i>Female</i>			4. RACE <i>Caucasian</i>			5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 30, 1893</i>			7. IF UNDER 24 HRS <i>MONTHS DAYS</i>			8. IF UNDER 24 HRS <i>HOURS MIN.</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>W. Virginia</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i>			MD			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home Maker</i>			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Kensington</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>3512 Hawick Court 20895</i>			
14. FATHER'S NAME FIRST <i>Charles</i>			MIDDLE <i>J.</i>			LAST <i>Barth</i>			15. MOTHER'S MAIDEN NAME FIRST <i>Clara</i>			MIDDLE <i>Nauss</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>216-46-5103</i>			17. INFORMANT (Son) <i>Howard W. Phillips, Jr.</i>			ADDRESS <i>Same as 13</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac Arrhythmia</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Congestive Heart Failure</i>												7 years			
(c) <i>Hypertension</i>												7 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) <i>the hospital</i> attended the deceased from <i>Oct 10, 1978</i> to <i>Dec 15, 1985</i> , that (I) <i>we</i> last saw the deceased alive on <i>April 12, 1985</i> , and that in (my) <i>our</i> opinion death occurred on the date and hour and from the causes stated above, <i>we</i> <i>did not</i> view the body after death.															
22b. SIGNATURE <i>Allen Nimetz</i>			22c. DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>12/11/85</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Allen Nimetz, M.D.</i>			22e. ADDRESS <i>5401 Western Ave, N.W. Washington, D.C.</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Dec. 18, 1985</i>			23c. NAME OF CEMETERY OR CREMATORIUM <i>Gate of Heaven</i>			23d. LOCATION CITY OR TOWN <i>Silver Spring, Mont.</i>			STATE <i>Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins, Jr.</i>			24b. ADDRESS <i>500 University Blvd. W., Silver Spring, Md. 20901</i>			25a. DATE REC'D. BY REGISTRAR <i>DEC 19 1985</i>			25b. REGISTRAR'S SIGNATURE <i>John W. Anderson</i>						



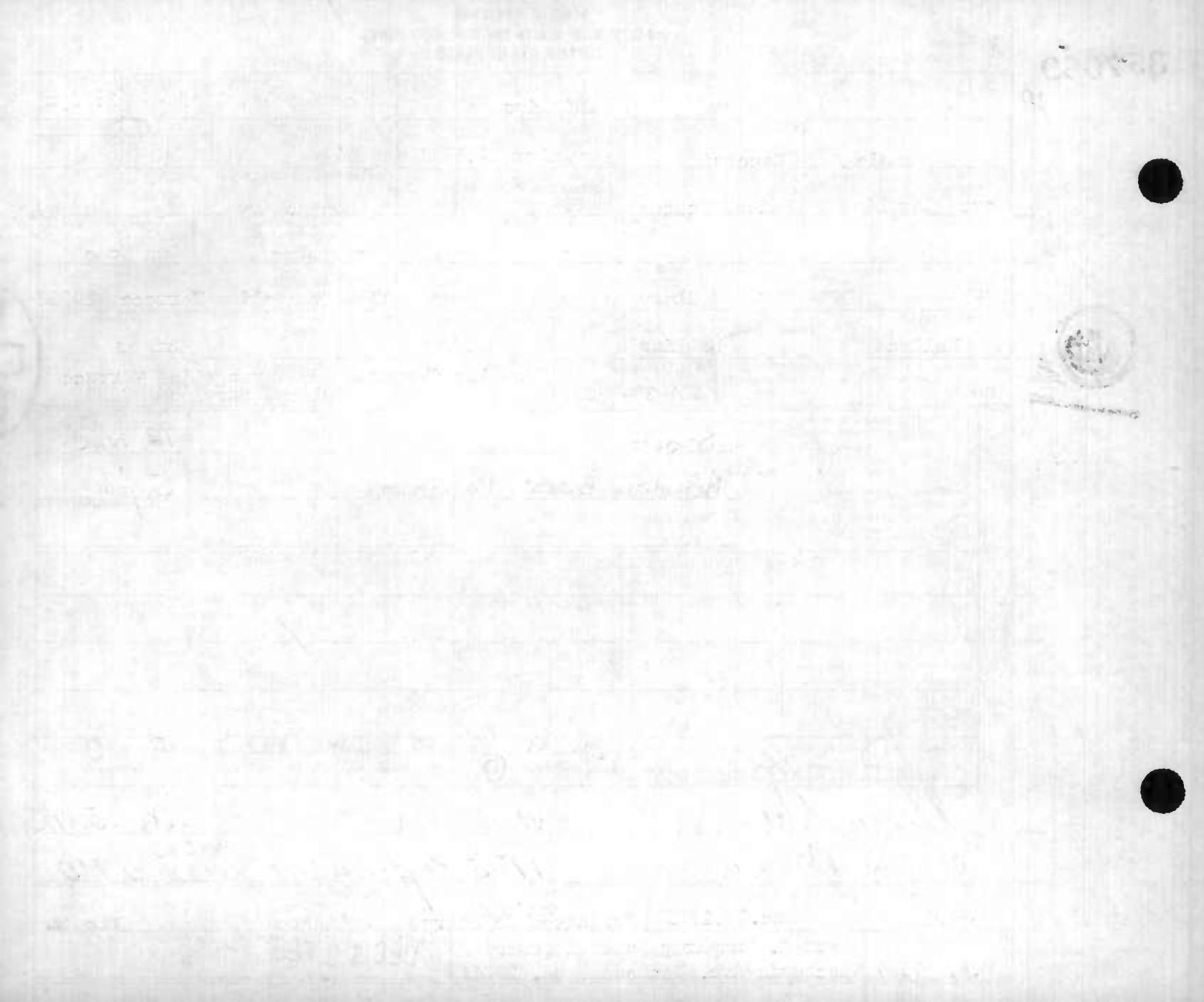
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, inform me.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					3535255
CERTIFICATE OF DEATH					REG. NO.
1 - FOR STATE REGISTRAR					
1a. DECEASED NAME (TYPE OR PRINT)		FIRST Phyllis	MIDDLE Hawkins	LAST Phillips	2a. DATE OF DEATH MONTH DAY YEAR December 14, 1985
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR November 24, 1921	6. AGE IN YEARS LAST BIRTHDAY 64 YRS IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Olney	12b. KIND OF BUSINESS OR INDUSTRY Own Home
14. FATHER'S NAME FIRST Wallace		MIDDLE Hawkins	15. MOTHER'S MAIDEN NAME FIRST Valley MIDDLE Griggs LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 224-20-9520		17. INFORMANT Douglas Shepard	ADDRESS 4005 Evangeline Terrace Olney, Maryland 20832
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Breast Carcinoma 5 years			
		DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET	CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from Dec. 14 1985 to Dec. 14 1985, that (I) (we) last saw the deceased alive on Dec. 14 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE <i>Alison Norris</i>		DEGREE MD		22c. DATE SIGNED Dec. 15, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alison Norris		ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS 14805 Physicians Lane Suite 272 Rockville MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 19, 1985		23c. NAME OF CEMETERY OR CREMATORIAL National Cemetery	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes P.A. 7557 Wisconsin Ave. Bethesda, Md. 20814				25a. DATE REC'D. BY REGISTRAR DEC 19 1985	
				25b. REGISTRAR'S SIGNATURE	



## **TO HOSPITAL OR ATTENDING PHYSICIAN:** The retained by the hospital or attending physician

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon copy and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be informed + once.

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 2 <sup>19</sup>	
Harold Glenn Pierce					MONTH	DAY	YEAR	12-2-85				
3. SEX M		4. RACE Caucasian		5. DATE OF BIRTH MONTH 5 DAY 11 YEAR 08			6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Head of Security			12b. KIND OF BUSINESS OR INDUSTRY Service Comm.					
13a. USUAL RESIDENCE IN NURSING HOME OR OTHER INSTITUTION (GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland		13c. COUNTY MONTgomery		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 807 Rowen Road 20910					
14. FATHER'S NAME FIRST Lemuel		MIDDLE L.	LAST Pierce		15. MOTHER'S MAIDEN NAME Florence			MIDDLE Rifenberg			LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 167-05-8968		17. INFORMANT (Wife) Virginia L. Pierce			ADDRESS same as 13e			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours		
18. CAUSE OF DEATH (Enter only one cause per line) (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro Vascular Accident												
DUE TO, OR AS A CONSEQUENCE OF (b) Central Anterior Sclerosis												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic, severe Congestive Heart Failure												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from Dec 2 1985, to Dec 2 1985, that (I) (we) lost saw the deceased alive on above, (I) (we) did not view the body after death.												
22b. SIGNATURE Robert J. Thibadeau												
22c. DATE SIGNED 12-2-85												
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert J. Thibadeau		22e. ADDRESS Rockville, MD 20852				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 6, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill			23d. LOCATION CITY OR TOWN Suitland		COUNTY Pri. GEO. Maryland			
24. FUNERAL DIRECTOR NAME Francis J. Collins		ADDRESS 500 University Blvd. W. Silver Spring, Md. 20901		25a. DATE REC'D. BY REGISTRAR DEC 5 1985			25b. REGISTRAR'S SIGNATURE					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that \_\_\_\_\_ be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by \_\_\_\_\_ should be detached for use as the burial-trust permit. Then please \_\_\_\_\_ with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE						8	5	3	5	2	5	7			
CERTIFICATE OF DEATH						REG. NO.									
1 - STATE REGISTRAR															
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST		2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
JAMES		HENRY	PRICE	JR.		DECEMBER 21, 1985						5:01A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
MALE		NEGRO		AUGUST 10, 1976		9			YRS.		MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE STATE OR FOREIGN		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			Montgomery County MD.						
Maryland		USA													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
BETHESDA		NIH, THE CLINICAL CENTER						student			--				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE						
MARYLAND		P.G.V.		BELTSVILLE		YES <input type="checkbox"/> NO <input type="checkbox"/>			4501 FRANKLIN TERRACE 20705						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST					
JAMES HENRY PRICE SR.					Liloutie						Harrilal				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			SAME AS ABOVE					
no		none		JAMES H. PRICE, SR (FATHER)											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		BACTERIAL PNEUMONIA AND SEPSIS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE LYMPHOBLASTIC LEUKEMIA										11 MONTHS			
{		DUE TO, OR AS A CONSEQUENCE OF (c) RENAL FAILURE AND URINARY TRACT OBSTRUCTION													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>SACRAL/RECTAL/SCROTAL CELLULITIS</b>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEBRUARY 26, 19 85, to DECEMBER 21, 19 85, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 21, 19 85, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, and we will _____ view the body after death.															
22b. SIGNATURE _____ DEGREE _____															
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22c. DATE SIGNED 12-22-85															
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard L. Heidemann MD		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD 20892													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-24-85		23c. NAME OF CEMETERY OR CREMATORIAL George Washington Cem.		23d. LOCATION CITY OR TOWN Adelphi		CITY OR TOWN		COUNTY Md		STATE			
24. FUNERAL DIRECTOR NAME Marshall's Funeral Home 4217 9th St NW: Washington, D.C.		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
DEC 30 1985 Schlesinger, Jr.															

CH1700



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 3  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned to the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3535258										
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR										
L. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Alva					Pryor		Female			Caucasian		February 10, 1894			91					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County Maryland MD.											
10. CITY OR TOWN OF DEATH Chevy Chase			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement & Nursing Center, Inc.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4201 Cathedral Avenue N.W. Washington 20016											
Washington DC																				
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Jennie			FIRST		MIDDLE	LAST									
John				Walsh								Paul								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. N/A			17. INFORMANT ADDRESS Alva P. Dodson 4201 Cathedral Avenue N.W. Washington, D.C. 20016 (Daughter)														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12/25/85</i>										
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral arterosclerosis</i>										<i>2 years</i>										
DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>ASHD corp osteoarthritis decubitus ulcer</i>																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>7/1</i> , 19 <i>75</i> , to <i>12/31</i> , 19 <i>85</i> , that (I) (we) lost saw the deceased alive on <i>12/26</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <i>Frank J. Fodor</i>										DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	DATE SIGNED <i>12/31/85</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>FRANK J. FODOR</i>										22e. ADDRESS <i>4201 CATHEDRAL AVE N.W. D.C. 20016</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan 3 1986		23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cemetery			23d. LOCATION CITY OR TOWN Silver Spring, Maryland		23e. COUNTY STATE										
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes P.A. 7557 Wisconsin Avenue Bethesda, Maryland 20814						25a. DATE REC'D. BY REGISTRAR JAN 3 1986			25b. REGISTRAR'S SIGNATURE <i>Julia Wilson-Pandell</i>											

citron



343080

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 2, 3, 4, AND 5 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3 WHICH SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1A AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

85. 35259

1- STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST <i>Mary</i>	MIDDLE <i>S/18YL</i>	LAST <i>Pusti</i>	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH Dec. 2	DAY 1985	YEAR 1985	
3 SEX	4. RACE	5 DATE OF BIRTH MONTH DAY YEAR	AGE (IN YEARS AT BIRTHDAY)	6 IF UNDER 1 YR MONTHS DAYS	7 IF UNDER 24 HRS HOURS MIN	8c. DATE PRONOUNCED DEAD	MONTH Dec. 2	DAY 1985	YEAR 1985
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10 CITY OR TOWN OF DEATH <i>Tak Park</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>7710 Maple Ave</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>CITY CLERK</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>CITY OF TAKE</i>	
13a. STATE <i>Md</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Tak Park</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>7710 Maple Avt 4th</i>	
14. FATHER'S NAME FIRST <i>FENNER</i>		MIDDLE <i></i>	LAST <i>CREMLE</i>	15. MOTHER'S MAIDEN NAME FIRST <i>GRACE</i>		MIDDLE <i>A.</i>	LAST <i>DANIEL</i>	ADDRESS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>234-20-8893</i>		17. INFORMANT <i>CAROL DINZ</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple injuries</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)									
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>fall</i>		21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR P.M. 12 2 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Jumped from balcony</i>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i>		21f. LOCATION STREET <i>Maple Ave Tak Park Mont. Md</i>		CITY OR TOWN <i>Tak Park</i>	COUNTY <i>Montgomery</i>	STATE <i>Md</i>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) M.D. <i>bgo</i>		MEDICAL EXAMINER				DATE SIGN <i>Dec. 21/85</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers</i>		ADDRESS <i>1919 Seminary Rd., S.S., Md.</i>							
23d. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23e. DATE <i>Dec. 6, 1985</i>		23f. NAME OF CEMETERY OR CREMATORIAL <i>HORSE PEN CHURCH CEM.</i>		23g. LOCATION CITY OR TOWN <i>HORSE PEN</i>		23h. COUNTY <i></i>	
24. FUNERAL DIRECTOR <i>Arthur Kellers</i>		25. ADDRESS <i>Takoma Funeral Home 254 Carroll St. N.</i>		26. DATE REC'D. BY REGISTRAR <i>DEC. 6, 1985</i>		27b. REGISTRAR'S SIGNATURE <i>Jeanne Gordon Pendell</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

305253

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

5 35260

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR									
Maggie			FATN		Quaiz	12	22	85	11 24										
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR										
F		Caucasian	MONTH	DAY	YEAR	60			IF UNDER 24 HRS										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8			9			YRS										
VIRGINIA		U.S.A.	MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input checked="" type="checkbox"/>	BALTIMORE CITY OR COUNTY OF DEATH			MONTH									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
SILVER SPRING		HOLY CROSS HOSPITAL									PRINTING CO.								
13a. STATE MARYLAND												13b. COUNTY PRI GEORGES MT. RAINIER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 2705 QUEENS CHAPEL RD 20822		
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME LUMMIE			ADDRESS		MD.										
ROBERT		L.	FAIN	16b. SOCIAL SECURITY NO. 228-24-5171			17. INFORMANT DAUGHTER MRS. GORDON HARTSPRING		3813 LINDA LANE ANNANDALE, VA. 22003										
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio respiratory Arrest</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immed							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Subdural hemorrhage, posterior fossa</u>																			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Extensive metastatic carcinoma</u>																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) lost saw the deceased alive on <u>12/22</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <u>Aron Primack</u>		22c. DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			DATE SIGNED <u>12/22/85</u>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																	
ARON PRIMACK		SILVER SPRING, MARYLAND																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION												
BURIAL		12/24/85		LAWSON CEMETERY			STUART		PATRICK VIRGINIA										
24. FUNERAL DIRECTOR NAME		FRANCIS J. COLLINS, JR.			500 UNIV. BLVD., W., SILVER SPRING, MD. 20901			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>DEC 27 1985</u>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office for at least 72 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL  
CERTIFICATE OF DEATH

REG. NO

1 - FOR  
STATE  
REGISTRATION

1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
William M. Quick						12/16/85			119 AM		
3. SEX		4. RACE		DATE OF BIRTH MONTH DAY YEAR			5. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		Caucasian		11-03-04			81 YRS.				
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH				
Indiana		U.S.A.					Montgomery County, MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Silver Spring		Holy Cross Hospital					Messenger Service (Retired)				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE	
Maryland		Montgomery		Silver Spring						10000 Brunswick Ave. #220 20910	
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Walter		Jacob		Mary Alice Mitchell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. ____-____-075-10-3204		17. INFORMANT Carol A. Auxier			18. ADDRESS 15801 Norman Drive Gaithersburg, Md. 20878			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Respiratory Failure											
DUE TO, OR AS A CONSEQUENCE OF (b) Endocarditis											
DUE TO, OR AS A CONSEQUENCE OF (c) Bronchogenic carcinoma											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Intestinal lymphoma, Aortic Anomaly											
19a. DATE OF OPERATION 10/24/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Aortic Anomaly			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____						
22a. I certify that (I) (this hospital) attended the deceased from 8/18/85, 19 85, to 12/15/85, 19 85, that (we) last saw the deceased alive on 12/15/85, 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Jay Weisner</i>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/16/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jay Weisner		22e. ADDRESS 7701 Radnor Rd Rockville, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/7/85		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Memorial Park			23d. LOCATION CITY OR TOWN Rockville, Maryland			COUNTY _____ STATE _____	
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 20852		ADDRESS			25a. DATE RECEIVED BY REGISTRAR DEC 13 1985			25b. REGISTRATION NUMBER 1331 Rockville Pike Rockville, Maryland 20852			

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the following are the results

of the experiments on the effect of acid

on the condition of the plants

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the results of the

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

5 35262

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>FLORENCE G. QUINN</i>						DEC. 9, 1955				8:49 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
<i>Female</i>		<i>WHITE</i>		<i>SEPT. 1, 1910</i>		75					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
<i>TEXAS</i>		<i>U.S.A.</i>				<i>MONTGOMERY CO.</i>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
<i>KENSINGTON</i>		<i>KENSINGTON Gardens Nursing Home</i>				<i>MANAGER</i>		<i>CAFETERIA</i>			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE ADDRESS			
<i>MARYLAND</i>		<i>MONTGOMERY</i>		<i>SILVER SPRING</i>		<i>8720 CAMERON ST. #220 / 20910</i>					
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
<i>(UNKNOWN)</i>					<i>(UNKNOWN)</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<i>NO</i>		<i>NONE</i>		<i>455-52-2698</i>		<i>JAMES J. QUINN (HUSBAND) SAME AS #13</i>		<i>WKS</i>			
18. CAUSE OF DEATH Enter only one cause per line for 18, (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic arteriosclerotic heart disease</i> YES											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cerebral arteriosclerosis</i> YES											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec. 24, 1955</i> , to <i>Dec. 9, 1955</i> . that (I) (we) last saw the deceased alive on <i>Dec. 24, 1955</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. DATE SIGNED <i>12/10/55</i>											
22c. SIGNATURE <i>Albert H. Grossman, MD</i>		22d. DEGREE <i>MD</i>		22e. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Albert H. Grossman, MD</i>		22g. ADDRESS <i>1106 Spring St. Silver Spring, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>Dec. 12, 1955</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>George Washington Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Adelphi, PG Co., Maryland</i>		23e. COUNTY		23f. STATE	
24. FUNERAL DIRECTOR NAME <i>W.W. Chambers Co., Inc.</i>		ADDRESS <i>8655 Georgia Ave. Silver Spring, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 16 1955</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT! If item 21 is marked or item 18 is checked, any injury, or other traumatic event, the

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remember to sign pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifying physician must initial this section.

**RECORDED 10/1**  
**RECORDED 10/1**

**MEDICAL CERTIFICATION**

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
365072											REG. NO. 3535263			
1. FOR STATE REGISTRAR			1. DECEASED NAME			LAST			2a. DATE OF DEATH			2b. HOUR		
(TYPE OR PRINT)			MARSHALL W. RACOOSIN						12 20 85			59 11 P.M.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male			White			June 10, 1930			55 YRS			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. DATE OF BIRTH			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Washington, DC			USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			MONTGOMERY					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
BETHESDA			SUBURBAN HOSPITAL			Developer			Real Estate					
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Maryland			Montgomery			Bethesda			7116 Nevis Road 20817					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Harry			C. Racoosin			579-36-0337			Mitchell Racoosin; 7116 Nevis Rd, Bethesda Md			Tannenbaum		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic Cardiovascular Disease</i>														
DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
12/20/85			Renal Transfusion			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>12/20</u> , 19 <u>85</u> , to <u>12/20</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>12/20</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
John A. Nardis M.D.			M.D.						12/21/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
John A. Nardis M.D.			8318 Wisconsin Ave Bethesda Md											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial			12-23-1985			Wash. Heb. Cong. Cem.			Washington, D.C.					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Danzansky-Goldberg Chapels;			Rockville, Md.			DEC 24 1985			John A. Nardis M.D.					
1170 Rockville Pike														

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

5 3 5 2 6 4

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>HAROLD</i>	MIDDLE <i>F.</i>	LAST <i>RAMSEY</i>	2a. DATE OF DEATH MONTH DAY YEAR <i>Jan. 22, 1906</i>	MONTH <i>Month</i>	DAY <i>Day</i>	YEAR <i>Year</i>	2b. HOUR <i>1:30 AM</i>
3 SEX <input checked="" type="checkbox"/> Male	4 RACE <input type="checkbox"/> White	5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 22, 1906</i>	6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.					
7a BIRTHPLACE <input type="checkbox"/> Kansas	7b CITIZEN OF WHAT COUNTRY? <input type="checkbox"/> U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <i>MONT.</i>	MD.						
10 CITY OR TOWN OF DEATH <i>BETHESDA</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>SUBURBAN</i>	12a USUAL OCCUPATION (THEIR DUTY FOR 48 HRS. OF WORK, IF ANY) <i>Retired Construction Foreman</i>	12b. KIND OF BUSINESS OR <i>Construction</i>							
13a STATE <input type="checkbox"/> Maryland	13b COUNTY <input type="checkbox"/> Montgomery	13c CITY OR TOWN <input type="checkbox"/> Rockville	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE <i>199 Rollins Ave. #412 20852</i>						
14 FATHER'S NAME FIRST <input type="checkbox"/> Owen	MIDDLE <input type="checkbox"/> Ramsey	LAST <input type="checkbox"/> Ramsey	15 MOTHER'S MAIDEN NAME FIRST <input type="checkbox"/> Lula	MIDDLE <input type="checkbox"/> Mae	LAST <input type="checkbox"/> Webb					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <small>(IF NO OR UNKNOWN)</small>	16b SOCIAL SECURITY NO <input type="checkbox"/> WW II <i>579-05-2716</i>	17 INFORMANT <i>Annabel Ramsey same as 18e</i>	ADDRESS <i>Adenocarcinoma Lung unknown</i>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma Lung</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>unknown</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>unknown</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>0 Past history of Colon Cancer &amp; Polychome Vas</i>										
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(IF EITHER NOTIFY MEDICAL EXAMINER)</small>	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>saw the deceased alive on 12/18/85 open heart in (my) opinion death occurred on the date and hour and from the causes stated above, (we) (did) view the body after death.</i>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE					
22a. I certify that (I) (the hospital) attended the deceased from Aug 20, 85, to Dec 18, 1985, that (we) last saw the deceased alive on 12/18/85 open heart in (my) opinion death occurred on the date and hour and from the causes stated above, (we) (did) view the body after death.						22c. DATE SIGNED <i>1/1/86</i>				
22b. SIGNATURE <i>H. C. M. Ramirez</i>						DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22c. PHYSICIAN'S NAME, TITLE OR HONOR <i>H. C. M. Ramirez</i>						22d. ADDRESS <i>30 W. Edmonson St. Baltimore, MD 21201</i>				
23a. BURIAL, CREMATION, REMOVAL <input type="checkbox"/> Burial	23b. DATE <i>12/21/85</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Gate of Heaven Cemetery</i>	23d. LOCATION CITY OR TOWN <i>Silver Spring, Maryland</i>							
24 FUNERAL DIRECTOR NAME <i>Tyson Wheeler Funeral Home, Inc.</i>	25a. DATE RECEIVED BY REGISTRAR <i>DEC 27 1985</i>	25b. REGISTRAR'S SIGNATURE <i>Jane Anderson-Pandore</i>								
1331 Rockville Pike, Rockville, Md. 20852										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

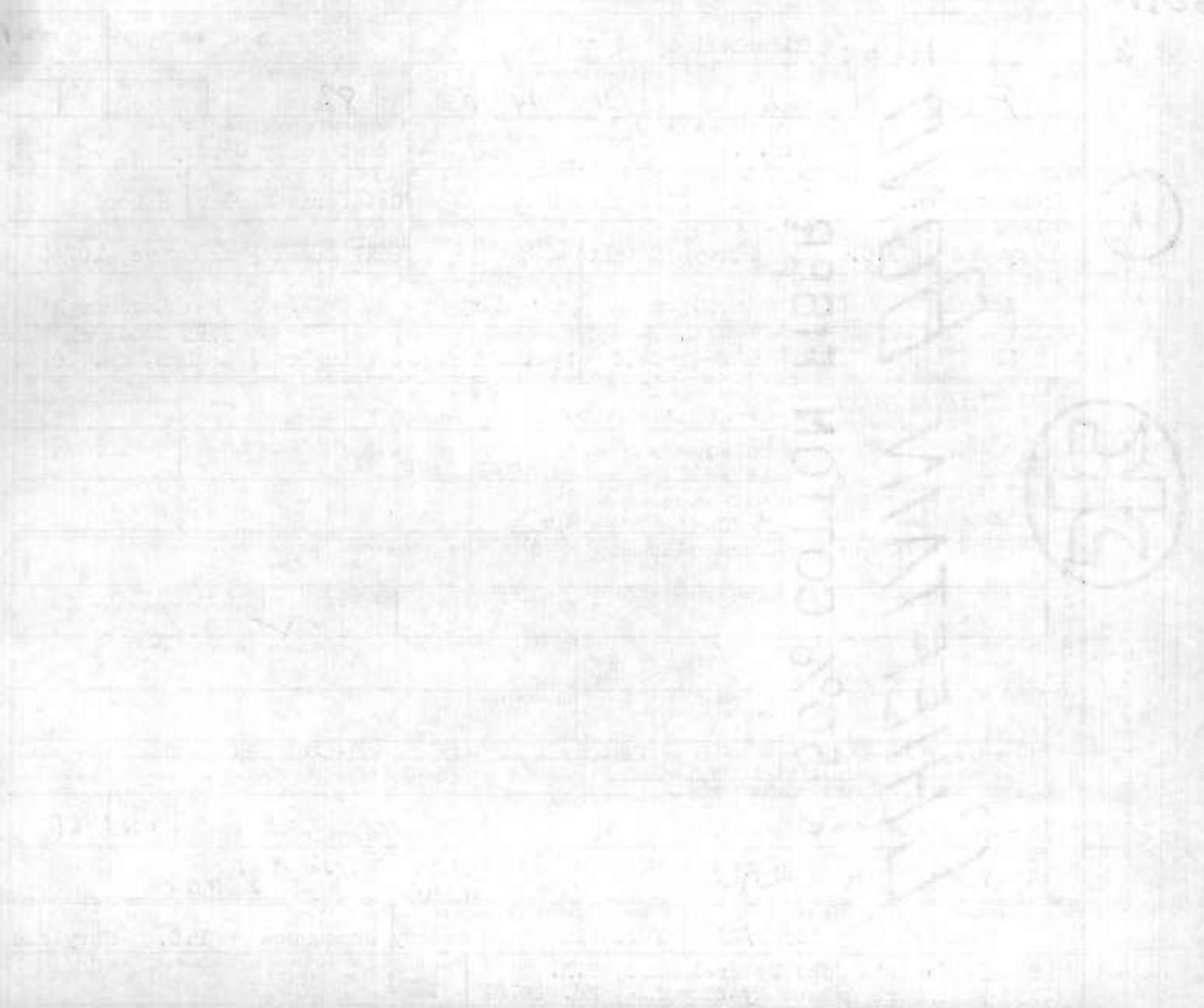
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed in the funeral director's office for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained for use as the burial/transit permit. If the death certificate is filed more than 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3535265
1. DECEASED NAME (TYPE OR PRINT)			FIRST ALICE	MIDDLE Elizabeth	LAST REAMY	2a. DATE OF DEATH Dec 22 1985	MONTH	DAY	YEAR	2b. HOUR 802 P M
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 11 DAY 14 YEAR 03			6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION Cafeteria Worker			12b. KIND OF BUSINESS OR INDUSTRY School			
13a. STATE Maryland		13b. COUNTY P.G.		13c. CITY OR TOWN Berwyn Heights			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14. STREET ADDRESS / ZIP CODE 8627 Cunningham Drive 20740	
14. FATHER'S NAME FIRST Arthur		MIDDLE J.		15. MOTHER'S MAIDEN NAME LAST Hogan			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-42-2422		17. INFORMANT Myrtle Philpot (Daughter)			ADDRESS 9795 Goodluck Road Lanham, Md. 20706			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST										
DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE										
DUE TO, OR AS A CONSEQUENCE OF (c) RENAL FAILURE										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	
22a. I certify that (I) (this hospital) attended the deceased from 10/21/1985 to 12/22/1985, that (I) (we) lost sow the deceased alive on 12/22/1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 12/27/85
22b. SIGNATURE Ananthakao		22c. DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANANTHA K RAO		22e. ADDRESS 831 UNIV BLVD #32 Silver Spring MD 20903								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/27/85		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood		COUNTY P.G. STATE Maryland	
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Md. 20781				25a. DATE REC'D. BY REGISTRAR DEC 27 1985			25b. REGISTRAR'S SIGNATURE			
ADMITTED										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the Burial/master permit. Then please remove carbon copies, pages 1 and 2, from the certificate and attach them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked as Item 18 shows any injury, an other traumatic event, the medical examiner must be notified.

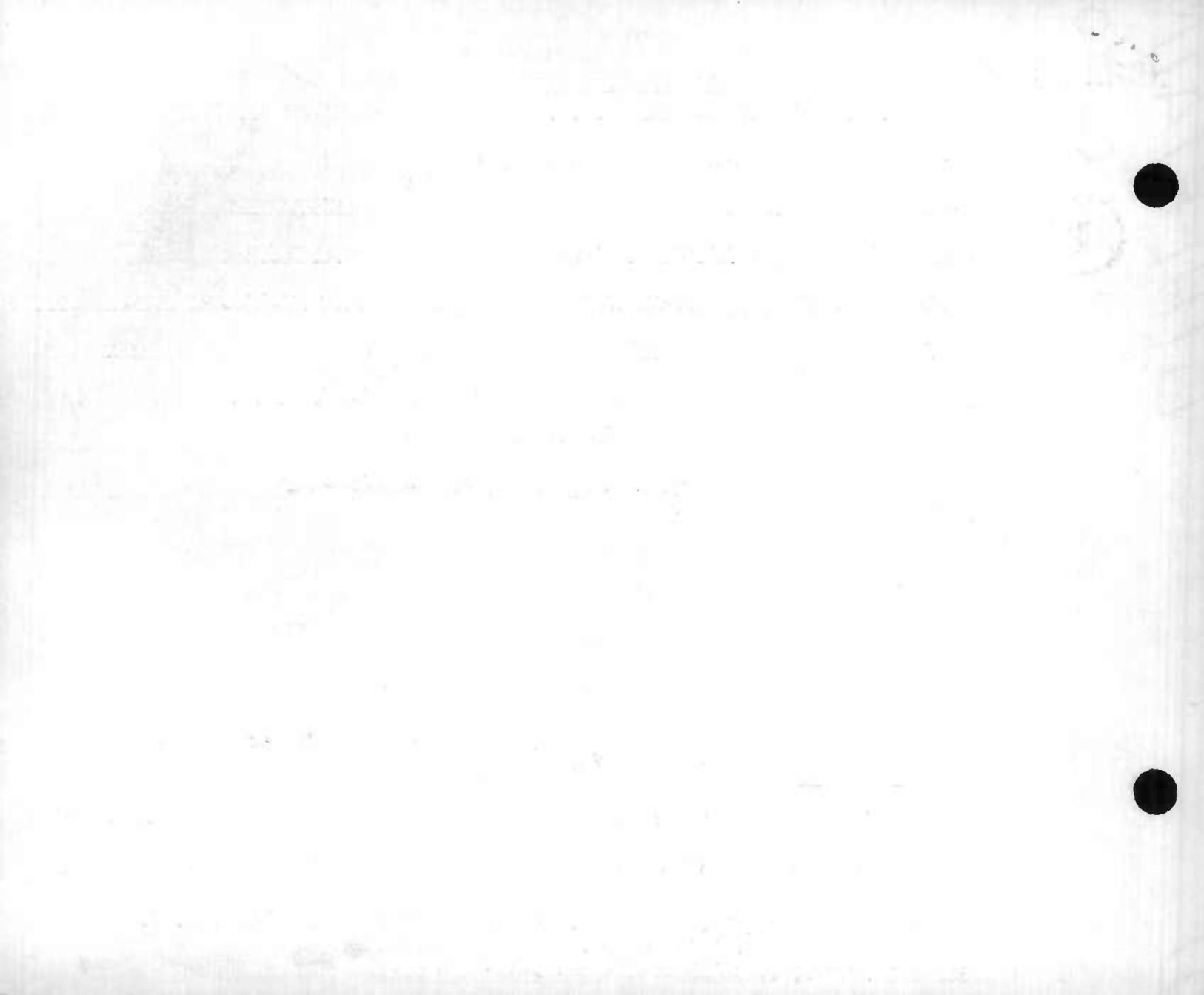
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 3535266

1 - STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		ARA MARY ELIZABETH REED SR. M. ANNUNCIATION REED C.S.C.			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
FEMALE		CAUCASIAN		SEPT 23, 1894		91			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MONTGOMERY	
CANADA		U.S.A.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
KENSINGTON		5000 STRATHMORE AVENUE		HOUSEKEEPER					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
MARYLAND		MONTGOMERY		KENSINGTON		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5000 STRATHMORE AVENUE 20895	
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		MIDDLE	LAST	
		PATRICK		REED	ELIZABETH			O'BRIEN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO		193-40-2286		SUPERIOR		SR. CATHERINE LASH, C.S.C.		SAME AS 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>generalized arterosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____  PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11-21, 1985, to 12-30, 1985, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Donald L. Bucy</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-30-85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DONALD L. Bucy</i>		22e. ADDRESS 809 VIERS MILL ROAD, ROCKVILLE, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/2/86		23c. NAME OF CEMETERY OR CREMATORIUM MT. OLIVET CEMETERY		23d. LOCATION CITY OR TOWN WASHINGTON, D. C.		COUNTY STATE	
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. 500 UNIV. BLVD. W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR JAN 02 1986		25b. REGISTRAR'S SIGNATURE <i>John Rendall</i>			



347079

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
KITTY			A.		REINER	December 1, 1985			12:45p <sub>m</sub>		
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)			7 IF UNDER 1 YEAR		
Female		Cauc.		Month Day Year Feb. 5, 1898		87			Months Days		
88		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS		
Balt., Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery County, MD.			Hours Min.		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
Bethesda		Suburban Hospital		Homemaker			Home				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a STREET ADDRESS / ZIP CODE					
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Rockville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			6121 Montrose Road (20852)		
14 FATHER'S NAME FIRST		MIDDLE		LAST		15 MOTHER'S MAIDEN NAME FIRST			LAST		
Abraham				Rosenfeld		Rose			Triger		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? NO			16b SOCIAL SECURITY NO. 579-07-4742			17 INFORMANT			ADDRESS 20817		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) <u>Acute Congestive Heart Failure</u>						4 hrs		
			(c) <u>Worsening Renal Insufficiency</u>						1 month		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.											
Non-insulin dependent diabetes; moderate Hypertension; Remote Mastectomy											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
-		-			-			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) -						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a I certify that (I) this hospital attended the deceased from saw the deceased alive on <u>12/11/1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) we did not view the body after death.											
22b. SIGNATURE <u>Stanley Cutler, MD</u>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED Dec. 2, 1985			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY CUTLER, M.D.		22e ADDRESS 6121 Montrose Rd Rockville MD 20852									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/3/85		23c. NAME OF CEMETERY OR CREMATORIAL B'Nai Israel Cong. Cemetery, Oxon Hill, P.G.; Maryland		23d. LOCATION CITY OR TOWN			COUNTY		STATE
24 FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852					25a. DATE REC'D. BY REGISTRAR DEC 8 1985			25b. REGISTRAR'S SIGNATURE <u>Julie Taylor</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 more be informed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, then phone remove carbon paper. Pages 1 and 2 should be filled in with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

BP

erotic

in the family you are 37 years old

006044

DIVISION OF VITAL RECORDS 301 W. PECOLTON ST. DALLAS, TEXAS 75201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1A. GIVE PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT ON FILE WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF PUBLIC HEALTH, BALTIMORE, MARYLAND, 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

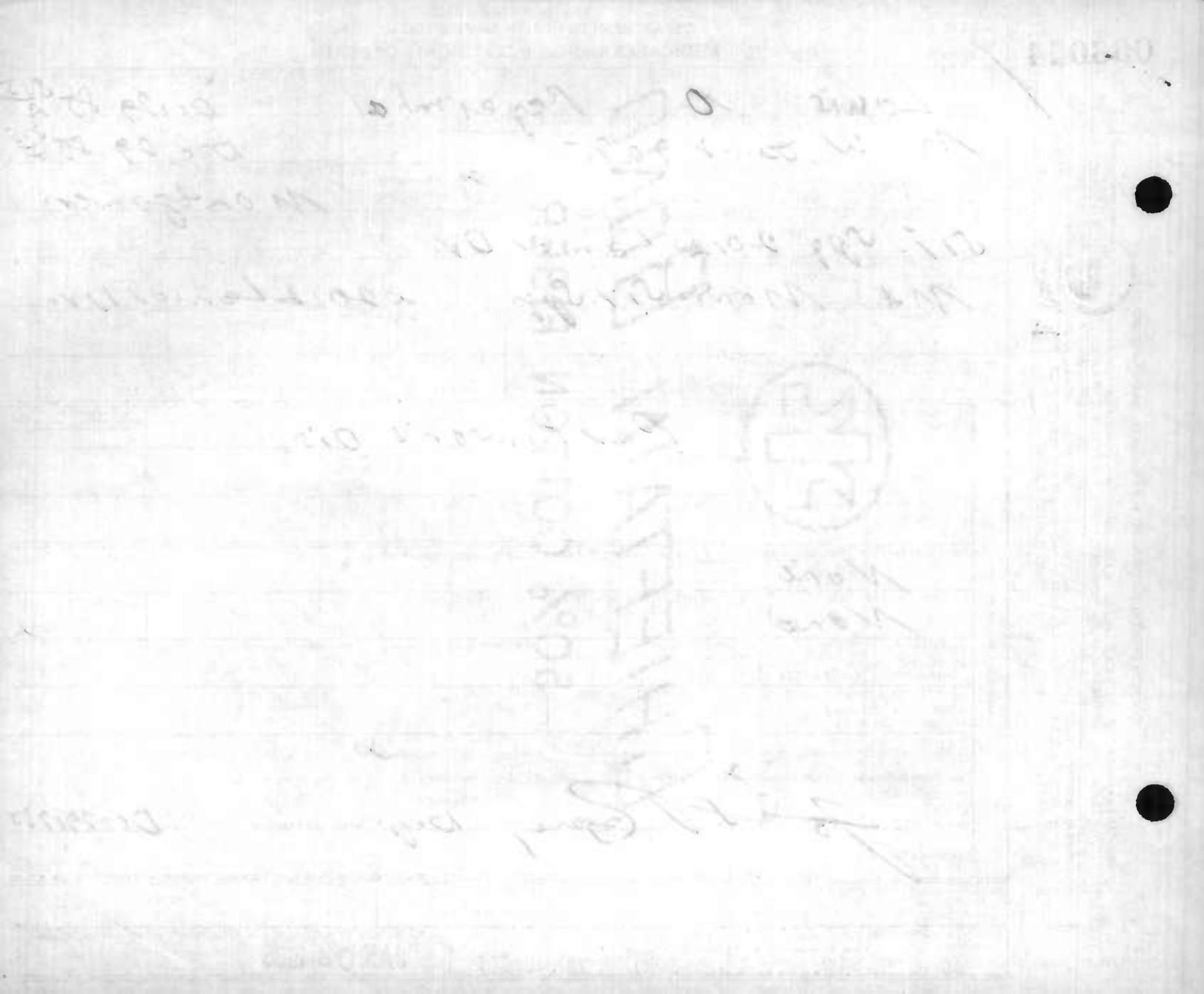
~~1- FOR  
STATE  
REGISTRAR~~

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG NO

卷之三

DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE KNOWN OF EST. DEATH MATED	MONTH	DAY	YEAR	2b. HOUR 8:30
Louis M. Regeimbal		0	Roger	Dec 29 1985	S	M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS YRS.	7. IF UNDER 1 YR. IF UNDER 24 HRS.				2c. DATE PRONOUNCED DEAD
M	W	Jan. 8 90 85	18 yrs.	MONTH	DAY	YEAR	2d. HOUR 8:30	
7a. BIRTHPLACE FOREIGN COUNTRY MINNESOTA	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
SJ. SPP	U.S.A.				Montgomery MD			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
SJ. SPP	2012 Lenior Dr.			PHYSIOLOGIST			DEPT OF AGR. 20901	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS				
MD	Montgomery	SJ. SPP	NO	2012 Lenior Dr.				
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST			
LOUIS	O.	REGEIMBAL, SR.	VALERIE		MENARD			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. _____  (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____  (c) _____	ADDRESS SAME AS 13 SON				
NO	217-52-5733	NEIL R. REGEIMBAL	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)								
None								
19a. DATE OF OPERATION None	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE	TITLE (SPECIFY) John S. Rogers M.D.			DATE SIGN. Dec 29 1985				
EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS 1919 SEMINARY RD. SILVER SPRING, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE 12/31/85	23c. NAME OF CEMETERY OR CREMATORIAL GATE OF HEAVEN	23d. LOCATION CITY OR TOWN SILVER SPRING	COUNTY MONT		STATE MD.		
24. FUNERAL DIRECTOR NAME	FRANCIS J. COLLINS, JR.			25a. DATE REC'D. BY REGISTRAR JAN 02 1986				
500 UNTV. BLVD. W. SILVER SPRING, MD. 20901				25b. REGISTRAR'S SIGNATURE				



357011

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE REPORT. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG NO. 35269		
1- STATE REGISTRAR			DECEASED NAME FIRST Benjamin			MIDDLE Anthony			LAST Rhoades			2a. DATE OF ESTI- MATED DEATH <input checked="" type="checkbox"/> 12/10/1985	MONTH DAY YEAR	2b. HOUR 12:52 P.M.
3 SEX Male		4. RACE White		5 DATE OF BIRTH MONTH DAY Nov. 18, 1916		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD 12/10/1985		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
10. CITY OR TOWN OF DEATH Silver Springs		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supply Officer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy								
13a. STATE Maryland		13b. COUNTY Montgomery Co.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 908 DeVere Drive / 20903						
14. FATHER'S NAME FIRST Benjamin		MIDDLE A.		LAST Rhoades, Sr.		15. MOTHER'S MAIDEN NAME FIRST Eva		MIDDLE May		LAST Emmons				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII		16c. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		17. INFORMANT Florence E. Rhoades (Wife)		ADDRESS Same as # 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?										
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE _____														
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec/16/85		23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem		23d. LOCATION CITY OR TOWN Arlington, Arlington, Virginia		COUNTY STATE						
24 FUNERAL DIRECTOR NAME Chambers Funeral Home		ADDRESS Silver Spring, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 19 1985		25b. REGISTRAR'S SIGNATURE Mandell								
DMMH - 17 (VR A15 ME (S))														

11075

100 ft. up

soil

200 ft. above

100 ft. above soil surface

soil surface

soil (100 ft. above surface)

CITCO

200

ft.

soil

surface

soil

surface

soil

surface

soil

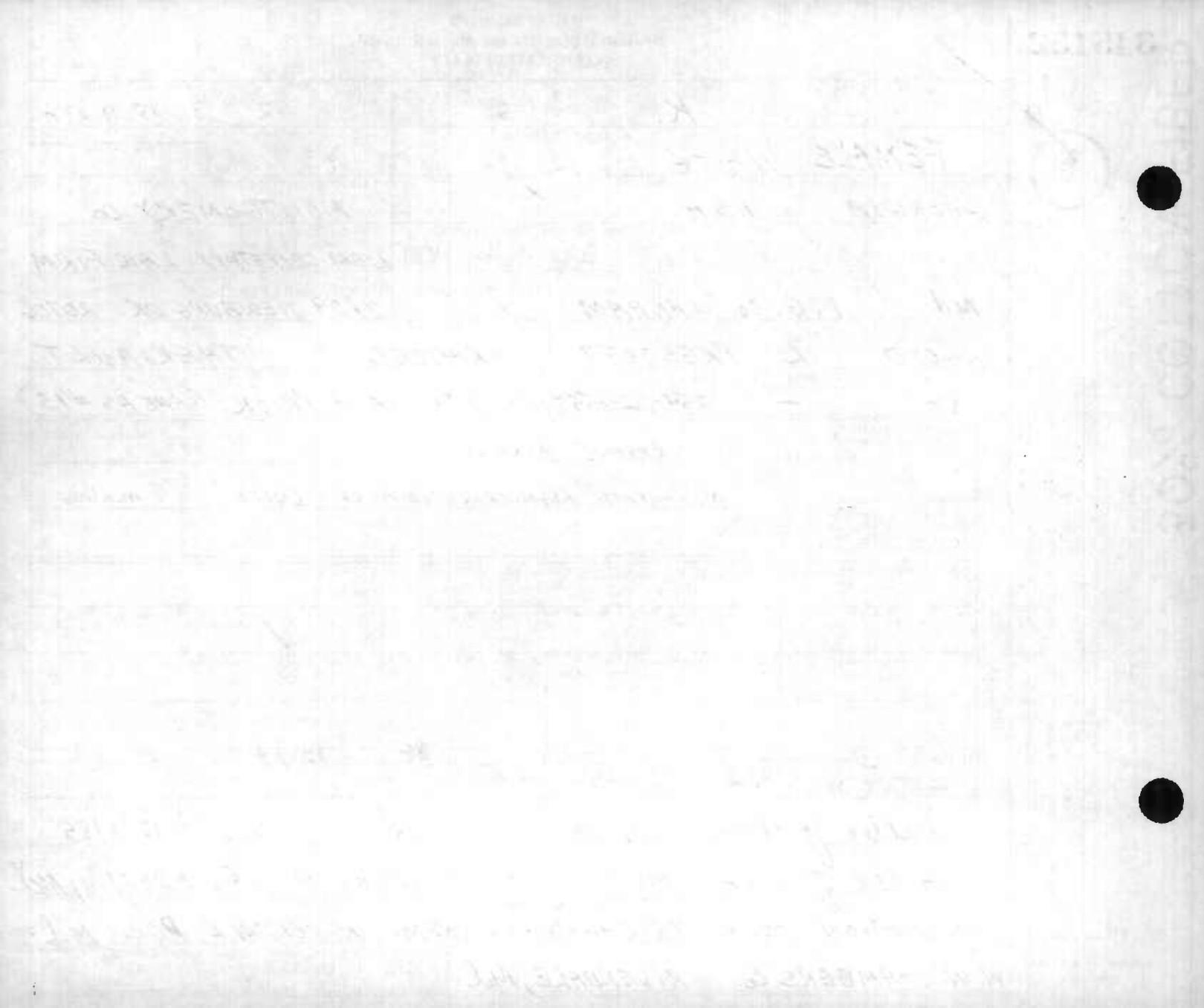
surface

soil surface

35270

REG. NO.

DECEASED NAME (TYPE OR PRINT)	Glenda K. Rice			DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE	WHITE	MONTH DAY YEAR 12 30 41	43	MONTHS	DAYS	HOURS	MIN.	
BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO., MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park	Washington Adventist Hospt			LEGAL SECRETARY		LAW FIRM		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7409 NEWBURG DR. 20706				
Lloyd	P. G. Co.	LANHAM	15. MOTHER'S MAIDEN NAME FRANCES THERIAULT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) No - 254-62-1557								
17. INFORMANT MRS PATRICIA A. PRIOR (SAME AS #13)								
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST								
DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC ADENOCARCINOMA OF LUNG 7 months								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a. I certify that (1) this hospital attended the deceased from 5/12, 1985, to 12/13, 1985, that (1) we last saw the deceased alive on 12/2, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) we did not view the body after death.								
22b. SIGNATURE Walter J. Urba MD PhD								
22c. DEGREE								
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. DATE SIGNED 12/3/85								
22e. ADDRESS 9300 UNIVERSITY BLVD E, ADELPHI, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE DEC. 4, 1985	23c. NAME OF CEMETERY OR CREMATORIUM CHAMBERS CREM.	23d. LOCATION CITY OR TOWN RIVERDALE, MD.	23e. COUNTY Md.	23f. STATE			
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.	ADDRESS RIVERDALE, MD.			25a. DATE REC'D. BY REGISTRAR DEC 9 1985	25b. REGISTRAR'S SIGNATURE			

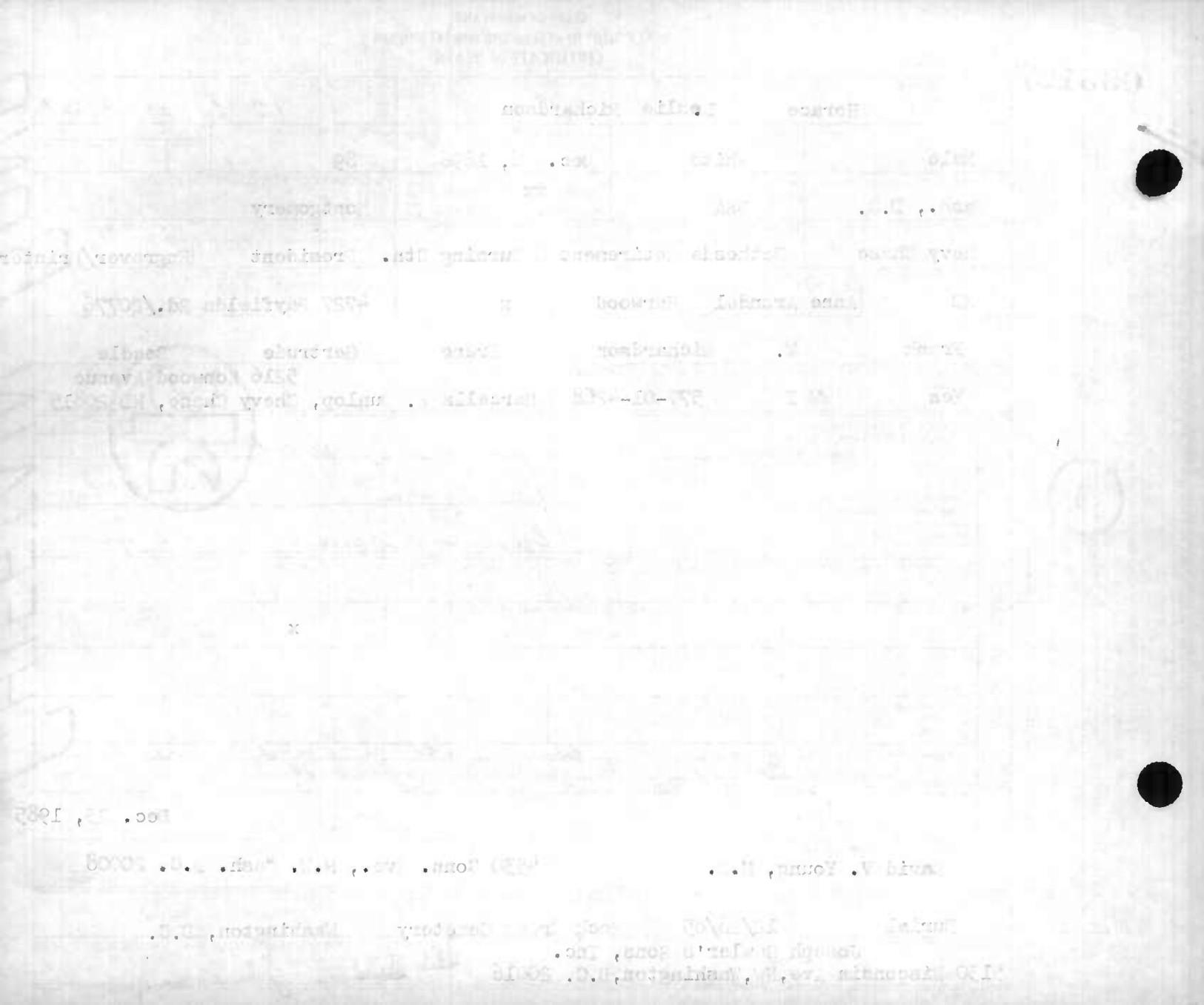


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please send it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. If item 21 is marked or item 18 shows any injury, or other condition, in the event, the medical examiner may be notified of it.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 5 35271									
1 - STATE REGISTRAR			2a. DATE OF DEATH 12 21 85							2b. HOUR 9:35 P.M.									
1. DECEASED NAME (TYPE OR PRINT) <b>Horace Leslie Richardson</b>			FIRST MIDDLE LAST			2c. NAME OF CEMETERY OR CREMATORIAL <b>Rock Creek Cemetery</b>			2d. LOCATION CITY OR TOWN <b>Washington, D.C.</b>										
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 6, 1896</b>			6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>		10. CITY OR TOWN OF DEATH <b>Chevy Chase</b>										
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bethesda Retirement &amp; Nursing Ctr.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) President																	
12b. KIND OF BUSINESS OR INDUSTRY Engraver/Printer										13a. STATE MD		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Harwood		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4727 Bayfields Rd./20776	
14. FATHER'S NAME FIRST Frank MIDDLE W. LAST Richardson			15. MOTHER'S MAIDEN NAME FIRST Irene MIDDLE Gertrude LAST Beedle																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW I			17. INFORMANT ADDRESS Marcella R. Dunlop, Chevy Chase, MD 20815													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Alzheimer's Disease</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 78 hours.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												6 years.							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1980</u> to <u>Dec. 21, 1985</u> , that (I) (we) last saw the deceased alive on <u>Dec. 10, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												22c. DATE SIGNED Dec. 23, 1985							
22b. SIGNATURE <i>D. V. Young</i>			22c. DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>													
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David V. Young, M.D.</b>			22e. ADDRESS <b>4530 Conn. Ave., N.W. Wash. D.C. 20008</b>																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE 12/28/85			23c. NAME OF CEMETERY OR CREMATORIAL <b>Rock Creek Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Washington, D.C.</b>										
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b>			25a. ADDRESS <b>5130 Wisconsin Ave., NW, Washington, D.C. 20016</b>			25b. DATE REC'D. BY REGISTRAR <b>DEC 31 1985</b>			25c. REGISTRAR'S SIGNATURE <i>John ...</i>										



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The  
retained by the hospital or attending physician

**TO. FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, ~~it~~ <sup>be filed</sup> in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

35212

REG. NO.

Page 1 of 10

## the traditional

*—longis longis iugulis*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. DECEASED NAME					FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
					Tyler	J.	Ritenour		12	16	85	3:35 p.m.
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		MONTH	DAY	YEAR	76		MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		U. S. A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Montgomery County, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Takoma Park		Washington Adventist Hosp.		Takoma Transfer, Owner, Ret.								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE				
Maryland		Montgomery		Takoma Park		<input checked="" type="checkbox"/> NO <input type="checkbox"/>		7301 Holly Ave. Tak. Pk. 20912				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
Milton				Ritenour	Martha Jane					Burner		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO. IF UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, ONE WAR OF DATES)		17. INFORMANT			ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Yes		U. S. Navy		577-05-5909			Fay Anderson				Greenbelt, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary occlusion												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Coronary arteriosclerosis, Adenovirus												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Diabetic Nephritis												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				<input type="checkbox"/> YES <input type="checkbox"/>			<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (has/had) attended the deceased from 1 June 1955 to 16 Dec 1985, that (we) last saw the deceased alive on 3 Dec 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) (did not) view the body after death.												
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)							16 Dec 85					
THOMAS P. FOGARTY												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR STATE					
Burial		Dec. 19, 1985		Rock Creek Parish			Washington, D. C.					
23e. FUNERAL DIRECTOR		Takoma Funeral Home		ADDRESS			23f. DATE REC'D. BY REGISTRAR					
Gather Weller		254 Carroll St. N. W.		D			23g. REGISTRAR'S SIGNATURE					
BP _____		ADDRESS		D			DEC 20 1985					
DHMH - 16 60M 7/84 (VRA 15, 4)												



Jan 1 1961

347019

ITEM NUMBER 4 PER.IH.CALL STATE OF MARYLAND  
FOR STATE 12-16-85 D.V. DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
REGISTRAR MEDICAL EXAMINER'S CERTIFICATE OF DEATH

35274

REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND FORWARD TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3, RETAIN PAGE 4 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED AS A BURIAL AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR		
BRIAN			Keith	ROBINSON		<input checked="" type="checkbox"/>	12 4	19	85	21 02		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.	2d. DATE PRONOUNCED DEAD		
M	WHITE	6 5 65	20 yrs.							12 4 1985 21 02		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED	<input checked="" type="checkbox"/>	NEVER MARRIED	<input type="checkbox"/>	WIDOWED	9. BALTIMORE CITY OR COUNTY OF DEATH		
MD		USA			WIDOWED	<input type="checkbox"/>	DIVORCED	<input type="checkbox"/>		MONTGOMERY MD		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA		SUBURBAN HOSPITAL					Construction			Construction Co.		
13a. STATE		COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS					
MD		FRANCIS		FRANCIS			1411 KEY PARKWAY			21701		
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	ADDRESS					
Harry L. Robinson				Barbara Ann Robinette								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
NO		219-88-7368		Mrs. Tammy L. Robinson, Frederick, MD								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:  888 IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost. (b) <u>HEAD TRAUMA</u> DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>ACUTE</u>  <u>36 HRS</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?					
12 3 1985							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12 3 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>TREE FELL HITTING HEAD</u>		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>CONSTRUCTION SITE</u>			21e. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
21f. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21g. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>CONSTRUCTION SITE</u>		21h. LOCATION STREET		21i. LOCATION CITY OR TOWN <u>ROCKVILLE MDT</u>			<u>MD</u>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>Francis C. Mayle</u>		TITLE (SPECIFY) M.D. <u>DEPT</u>		MEDICAL EXAMINER		DATE SIGNED <u>12/5/85</u>						
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS <u>Sue Wisconsin Ave. Bethesda MD</u>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 12-08-1985	23c. NAME OF CEMETERY OR CREMATORIAL Oldtown Cemetery	23d. LOCATION CITY OR TOWN <u>Oldtown</u>	COUNTY	STATE	
24. FUNERAL DIRECTOR NAME James F. Scarpelli, Cumberland, MD 21502		ADDRESS		25a. DATE REC'D. BY REGISTRAR <u>456. 1985</u>			25b. REGISTRAR'S SIGNATURE <u>John J. Wilson</u>					
DHMH - 17 (VR A15 ME (5))												

COTTON

Manufacturing Co., Inc.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The  
attending physician or attending physician

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, ~~fill in~~ in the funeral director, page 3 should be detached for use as the **Burial Permit**. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

**IMPORTANT.** If both 21st marked or 18th marked, then both dates are valid.

executed with impunity after death. Page 4 may be

executed without trial after death. Page 4 may be

law requires that the death certificate be

TO HOSPITAL OR ATTENDING PHYSICIAN: The

DHMH - 16 60M 7/B4  
(VRA 15, 4)

345115

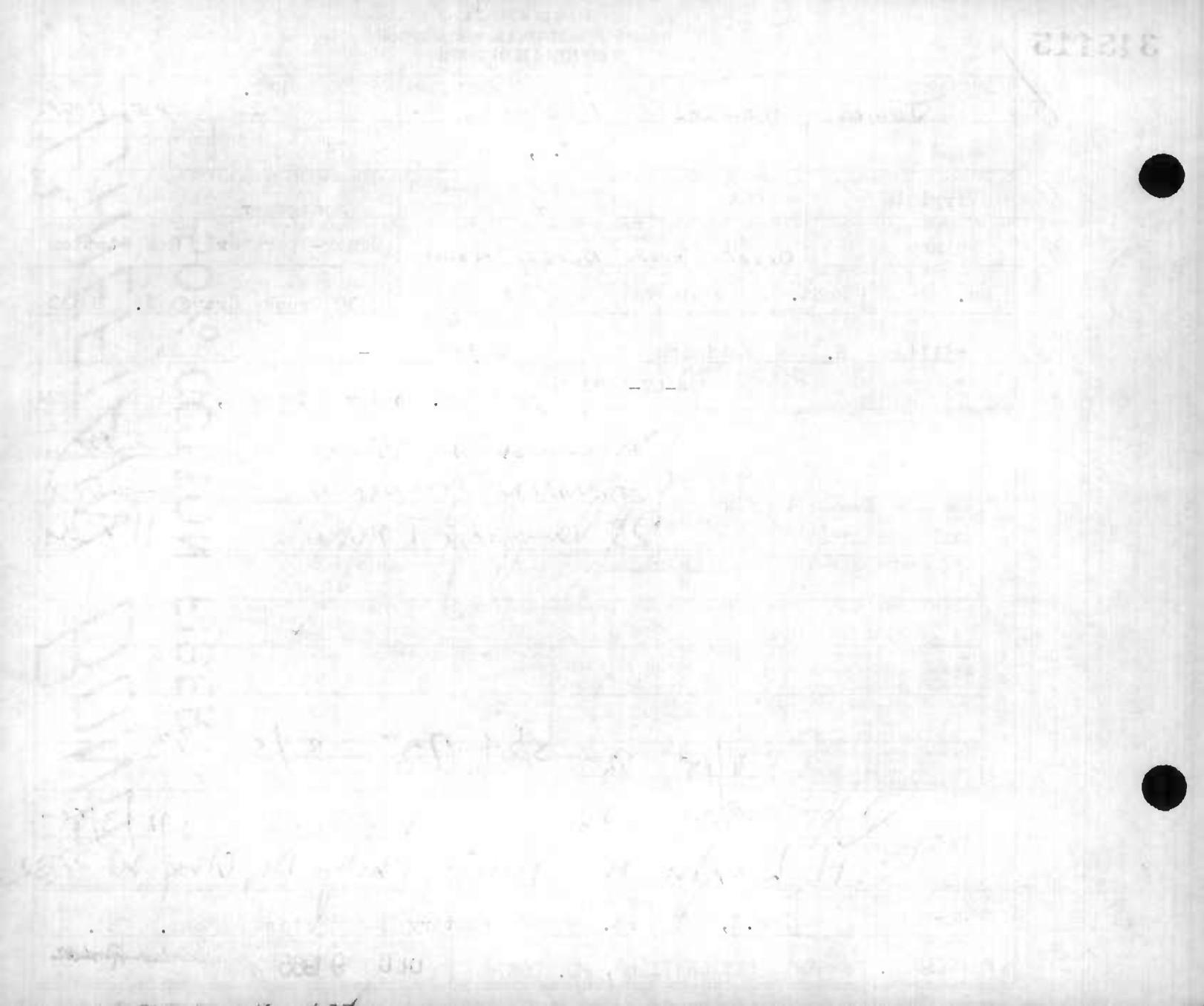
**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 0 3 5 2 7 5

REF. NO.

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	ROBINSON	REG. NO.		
James Howard Robinson SR.						DEC. 12 3 85	1:00PM		
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
MALE	WHITE	DEC. 5, 1910			74		MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Virginia		USA					Montgomery MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Olney		Brooke Grove Nursing Home			Owner-Operator		Gas Station		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.	13b. COUNTY Mont.	13c. CITY OR TOWN Olney	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 18430 Brooke Grove Rd. 20832			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. ADDRESS Winks			
William H. Robinson			Annie -						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. J/F 163, GIVE MONTH & DAY 224-07-0692			17. INFORMANT Beulah R. Dozier Thomson, Georgia 30824			
18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR ITEM 18, PART 1) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertension - aspiration</i>									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days 11 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>1983</u> , to <u>1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Dr. Francis H. Barber</i>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/3/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Francis H. Barber</i>		22e. ADDRESS <i>18111 Pr Phylip Dr, Olney MD 20832</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 5, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Carmel Cemetery		23d. LOCATION CITY OR TOWN Sunshine County Md.			
24. FUNERAL DIRECTOR FRANCIS H. BARBER		ADDRESS LAYTONSVILLE, MD. 20879			25a. DATE REC'D. BY REGISTRAR DEC 9 1985		25b. REGISTRAR'S SIGNATURE <i>Davidson Pendleton</i>		

312412



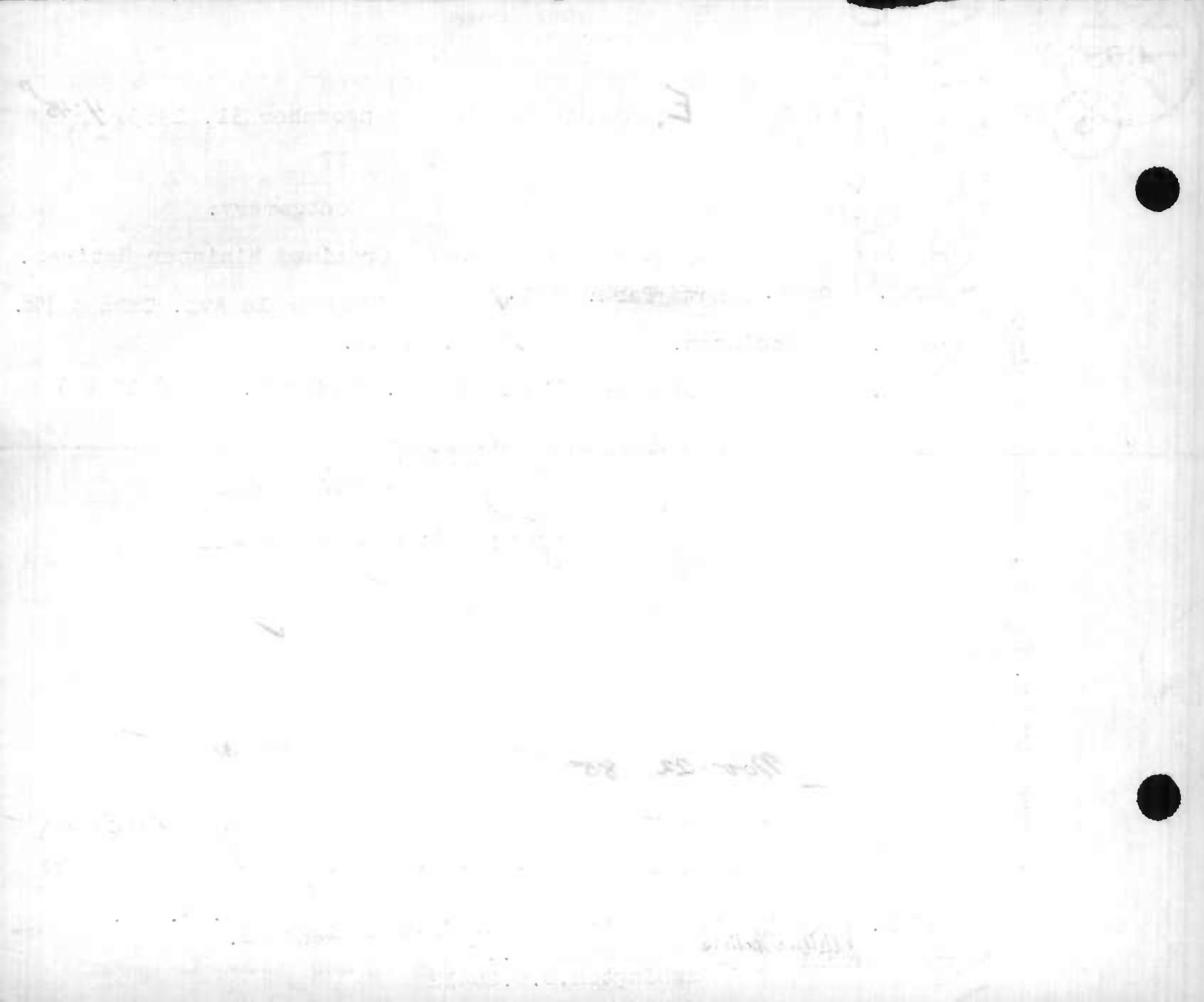
008147

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 85 35270

1 - STATE  
STANDARD FORM  
REV. 1-65  
MAY 1965  
100-64750-1

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
virgil E. Robinson						december 31	1985			4:45 P.M.			
3. SEX	M	4. RACE	W	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	IF UNDER 24 HRS		
				1	19	10	8	77	YRS.	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	California	7b. CITIZEN OF WHAT COUNTRY?	U.S.	MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
10. CITY OR TOWN OF DEATH	Takoma Park.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Heritage Health Care Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Maryland.	Montgomery County	Takoma Park.	Retired										
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION) (TYPE RESIDENT'S BRANCH OF ADMISSION)			14. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13a. STREET ADDRESS / ZIP CODE		20912						
Montgomery. Takoma Park. ring					7309 Maple Ave. Takoma Pk.								
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME		MIDDLE	LAST						
Dores E.			Robinson.	Ella M. White.									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		579-50-658	17. INFORMANT		ADDRESS		( 13 e )					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arhythmia chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
DUE TO, OR AS A CONSEQUENCE OF (c) Alzheimer's disease Alzheimer's syndrome													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(b):													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE					
22a. I certify that (I) (this hospital) treated the deceased from Dec 22, 1985, to Dec 31, 1985, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (view) the body after death.													
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								12/31/85			
Abraham Dabbla		4404 Queen St. Rd. Riverdale MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		P. C. COUNTY Md.		STATE			
Burial.		Jan 6, 1986		George Washington		Riggs Rd.							
24. FUNERAL DIRECTOR		f. Arthur Miller		254 Carroll St., NW		25a. DATE REC'D. BY VITAL REGISTRAR		REGISTRAR'S SIGNATURE					
Takoma Funeral Home				Washington, D.C. 20012		JAN 6 1986		John J. Miller					
DHMH - 16 50M 4/83 (VRA 15, 4)													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8535271				
										REG. NO.				
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
355108			Rodolfo NMN					Rodriguez	12-16-85				545 AM	
3 SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS (LAST BIRTHDAY))			IF UNDER 1 YEAR		
Male			White			MONTH	DAY	YEAR	44	MONTHS	YEARS	IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH					
Mexico			Mexico			MARRIED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	Montgomery				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Ta Kona Park			Washington Adventist Hosp			Waiter			Restaurant					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE				
13b. COUNTY										13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Maryland										Montgomery	Rockville	13e. STREET ADDRESS / ZIP CODE		
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME				
First Ysauro			Middle			Last Rodriguez	First Maria			Middle Padilla				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO OR UNKNOWN			16b. SOCIAL SECURITY NO.			17. INFORMANT (Mother)			ADDRESS					
No			218-92-4095			Maria Rodriguez			Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cystomegalovirus Infection</u> (c) <u>Pneumonia</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (1) (this hospital) deceased from November 1, 1985, to December 16, 1985, that (1) (we) last saw the deceased alive on December 16, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 12/16/85				
22b. SIGNATURE <i>Jorge H. Forcada MD.</i>										ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DR. JORGE H. FORCADA</i>										22e. ADDRESS 1100 Springs St. Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 12/18/85			23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven			23d. LOCATION CITY OR TOWN Silver Spring, Mont. Md.					
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. ADDRESS 500 Univ. Blvd. W., Silver Spring, Md. 20901										25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 27 1985				

БИБЛІОТЕКА  
ДЛЯ СОВЕТСКОГО ЧИТАТЕЛЯ



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the time of death. Please do not delay.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial permit. Then please review the following pages 1 and 2 which should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other than normal, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 35278						
1. FOR STATE REGISTRAR			2. DATE OF DEATH 12 18 85							2b HOUR 11:18 am						
1. DECEASED NAME (TYPE OR PRINT)			FIRST LOUIS	MIDDLE (NMN)	LAST ROMANO											
3. SEX Male			4. RACE White		5. DATE OF BIRTH MONTH Mar. DAY 5 YEAR 1907		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR 78		IF UNDER 24 HR. MONTHS 9 YRS. 12 DAYS HOURS 12 MIN.							
7a. BIRTHPLACE COUNTRY Italy			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD.									
10. CITY OR TOWN OF DEATH Olney			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brick-layer-Contractor											
12b. STATE Maryland			13. COUNTY Carroll		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 21784 6122 Old Washington Rd.									
14. FATHER'S NAME FIRST Unknown			MIDDLE		15. MOTHER'S MAIDEN NAME Unknown											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNKNOWN)			16b. SOCIAL SECURITY NO. WW 2		17. INFORMANT Grace R. Romano, Same As #13		ADDRESS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral confluent pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Squamous cell carcinoma, right lung DUE TO, OR AS A CONSEQUENCE OF (c) S/P radiation rx with radiation pneumonitis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Months Weeks						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None																
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (the hospital) attended the deceased from say the deceased alive on 18 Dec 1985, and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										22c. DATE SIGNED 19 Dec 85						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12-19-1985		23c. NAME OF CEMETERY OR CREMATORIAL Security Process		23d. LOCATION CITY OR TOWN Catonsville, Baltimore, Md.									
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md.										DEC 23 1985 John J. [Signature]						

so on than anything else. I think I have more trouble with  
the stock market than with anything else. However, I have been  
very successful in my business. I have had many successes  
and failures. I have learned from both. I have also learned  
from my mistakes. I have learned that it is important to  
have a good plan and to stick to it. I have also learned  
that it is important to be patient and to wait for the right  
opportunities. I have learned that it is important to be  
confident in your abilities and to believe in yourself.

X

1

2124  
2124

I have also learned that it is important to be persistent and  
not give up easily. I have learned that it is important to be  
realistic about your goals and to set them accordingly. I have  
also learned that it is important to be open-minded and to be  
willing to learn from others. I have learned that it is important  
to be honest and to be transparent in your business. I have  
also learned that it is important to be ethical and to do what is  
right. I have learned that it is important to be kind and to be  
considerate of others. I have learned that it is important to be  
grateful and to be thankful for what I have. I have learned  
that it is important to be positive and to be optimistic. I have  
also learned that it is important to be hard-working and to be  
determined. I have learned that it is important to be creative  
and to be innovative. I have learned that it is important to be  
adventurous and to be willing to take risks. I have learned  
that it is important to be resilient and to be able to bounce back  
from setbacks. I have learned that it is important to be  
responsible and to be accountable. I have learned that it is  
important to be a good citizen and to be a good member of  
society. I have learned that it is important to be a good  
parent and to be a good role model. I have learned that it is  
important to be a good friend and to be a good neighbor.  
I have learned that it is important to be a good person.

351093

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

35 35279

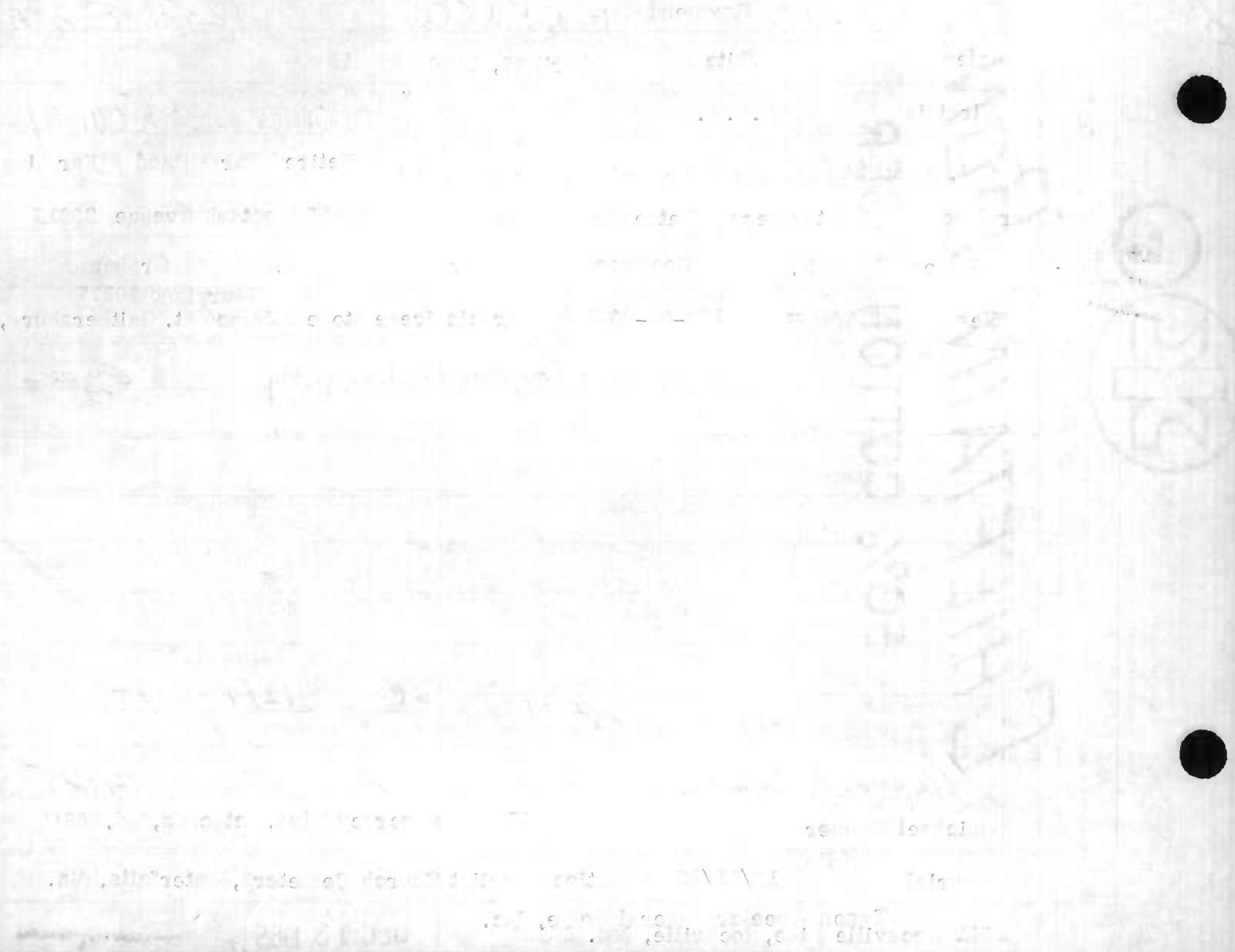
1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>James</i>	MIDDLE <i>Raymond</i>	LAST <i>Rookwood</i>	2a. DATE OF DEATH MONTH <i>April</i>	MONTH <i>12</i>	DAY <i>09</i>	YEAR <i>1985</i>	2b. HOUR <i>6:39 AM</i>		
3. SEX Male			4. RACE White		5. DATE OF BIRTH MONTH <i>April</i>		DAY <i>27</i>	YEAR <i>1906</i>	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS <i>79</i>			
7a. BIRTHPLACE STATE OR FOREIGN <i>Virginia</i>			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i>					
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i>		12. USUAL OCCUPATION Retired Farm Hand				13. KIND OF BUSINESS OR INDUSTRY Farming			
14. FATHER'S NAME FIRST <i>James</i>			15. MIDDLE <i>E.</i>	16. LAST <i>Rookwood</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>10013 Montauk Avenue 20817</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>			16b. SOCIAL SECURITY NO. WW II		17. INFORMANT <i>Gracie Irene Stone 2 James St. Gaithersburg,</i>		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Ischemic + Congestive Cardiomyopathy</i>												
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/29</u> , 19 <u>85</u> , to <u>12/9</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>12/9</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Michael Emmer</i>			22c. DEGREE <i>MD</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>12/9/85</i>			
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Michael Emmer</i>			22g. ADDRESS <i>6316 Democracy Blvd. Bethesda, Md. 20817</i>									
23a. BURIAL, CREMATION, REMOVAL (SPEC) <i>Burial</i>			23b. DATE <i>12/11/85</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Antioch Baptist Church Cemetery, Waterfalls, Va.</i>			23d. LOCATION CITY OR TOWN			
24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home, Inc.</i>			25a. DATE REC'D. BY REGISTRAR <i>DEC 13 1985</i>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>						
1331 Rockville Pike, Rockville, Md. 20852												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be detached for use as the burial-transit permit. Then please remove carbon paper. Please forward this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. If item 21 is marked or item 22 is checked, attach a copy of the death certificate to the burial-transit permit.



002116

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

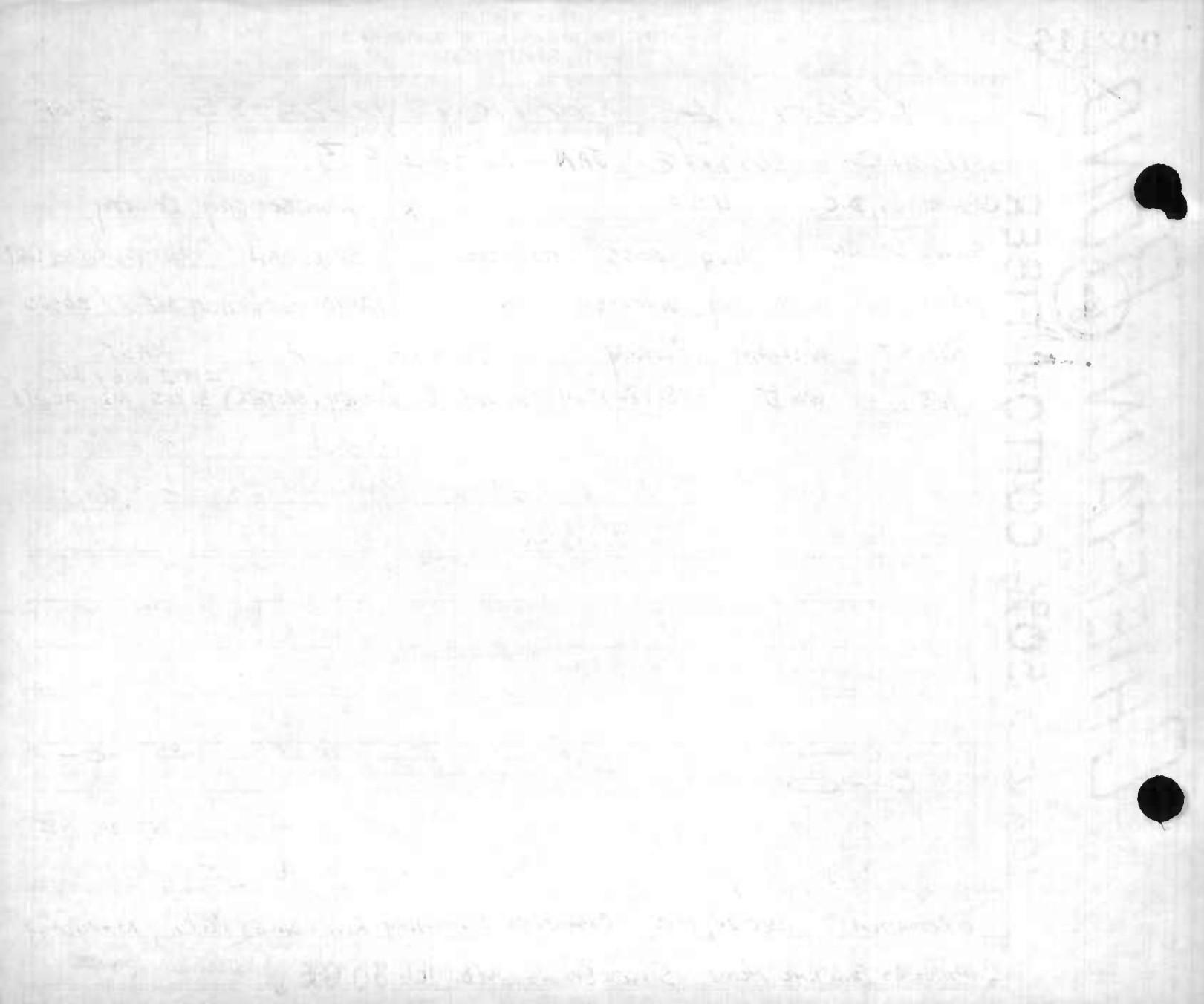
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Robert L. Rooney</i>						<i>12-23-85</i>				<i>3:45PM</i>	
3. SEX	4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS			
<i>Male</i>	<i>white</i>	<i>JAN - 16 - 22</i>			<i>63</i>	MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
<i>WASHINGTON, D.C.</i>	<i>U.S.A.</i>				<i>MONTGOMERY County MD.</i>						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
<i>SILVER SPRING</i>	<i>Holy Cross Hospital</i>					<i>SALESMAN</i>					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
<i>Maryland</i>	<i>MONTGOMERY</i>	<i>WEATON</i>				<i>12410 CONNECTICUT AVE. / 20906</i>					
4. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. KIND OF BUSINESS OR INDUSTRY				
<i>ROBERT</i>	<i>William</i>	<i>Rooney</i>		<i>CAMILLA</i>			<i>OVERSEAS SERVICE CORP.</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for part 1a, b, and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
<i>YES</i>	<i>578-18-1864</i>	<i>THOMAS C. Rooney (BROTHER)</i>	<i>Respiratory Arrest.</i>			<i>~ 6 days</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Inpiration Pneumonia.</i>						<i>~ 3 days.</i>					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Stroke</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED  WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that <input type="checkbox"/> (his hospital) attended the deceased from <i>12-16-85</i> to <i>12-23-85</i> , the <input type="checkbox"/> last saw the deceased alive on <i>12-23-85</i> , and that in my <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (I) <input type="checkbox"/> (he) did not view the body after death.											
22b. SIGNATURE <i>Christopher L. Unger</i> DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DATE SIGNED <i>DEC. 24, 1985</i>											
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Christopher L. Unger</i>			22d. ADDRESS <i>8218 Wisconsin Av. Bethesda, MD</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>DEC. 24, 1985</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Chambers Crematory</i>			23d. LOCATION CITY OR TOWN <i>RIVERDALE, PG Co. Maryland</i>		23e. DATE REC'D. BY REGISTRAR / REGISTRAR'S SIGNATURE <i>DEC 30 1985 Judith Davidson-Randall</i>			
24. FUNERAL DIRECTOR NAME <i>Chambers Funeral Home</i>		ADDRESS <i>Silver Spring, MD.</i>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted with the claim after death. Page 4 more

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and stamped with the funeral director's name and address, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Please attach this certificate to the death record in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked  (I), do not sign this certificate.



006137

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, USING THE FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES.  
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 5 2 3 1

REG. NO.

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/>	MONTH	DAY	YEAR	2b. HOUR  M		
		Richard	Steven	Ross	12/23/19	85					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY 24 YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR  M 1:21 A M	
Male	White	Nov. 13, 1961	24			12/23/19	85				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.A.					Montgomery County			MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Silver Spring		East Randolph Road			Assist. Sales Mgr.		Hahn Shoes				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/>		12644 English Orchard Ct.; 20906			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		Dubinsky			
David			Ross	Florence							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		M1. 20906			
NO		215-46-4025		David Ross; 12644 English Orchard Ct.; S. Spg							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8151 Cranio-cerebral Trauma										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:07 AM 12/23/19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) passenger in auto that lost control		21f. LOCATION STREET		CITY OR TOWN		STATE	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway				East Randolph Rd., Silver Spring, Montg., Md.					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>						and in my opinion			
ACTUAL SIGNATURE		TITLE (SPECIFY)						M.D. Assistant			MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT)		Gregory R. Kauffman, M.D.						ADDRESS			111 Penn St.
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 12/24/85		23c. NAME OF CEMETERY OR CREMATORIUM King David Mem. Garden		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial						Falls Church; Fairfax; Va.					
24. FUNERAL DIRECTOR NAME		DANZANSKY-GOLDBERG MEM. CHAPELS, INC.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
		1170 Rockville Pike; Rockville, Md. 20852						DEC 30 1985		John Danzansky	
07/84 25M	BP										
DHMH - 17 (VR A15 ME (5))											

701600



008146

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR										
<i>EDNA OLIVE ROYER</i>				12 28 95	10 08																
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR											
FEMALE		CAUC		MONTH	DAY	YEAR	94			IF UNDER 24 HRS											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.			9.			10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
NEW JERSEY		U.S.A		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			BALTIMORE CITY OR COUNTY OF DEATH			MONTGOMERY MD.			TAKOMA PARK			WASHINGTON ADVENTIST HOSPITAL			HOMEMAKER		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE											
MD		MONT		TAKOMA PARK			YES <input type="checkbox"/> NO <input type="checkbox"/>			7051 CARROLL AVE 20912											
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME																
EDGAR				MILES	SUE																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS														
NO		194-20-4162		EDNA O. HELMS			8111 ROANOKE AVE. TP														
18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) ACUTE HYPO CARDIAL INFARCT HOURS																			
(b) HYPERTENSIVE- ATHEROSCLEROTIC HEART DISEASE YRS.																					
(c) _____																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE							
22a. I certify that (I) (this hospital) attended the deceased from SPRING- MAY 19 72 to DEC. 28 19 95, that (I) (we) lost the deceased alive on DEC. 28 19 95, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																					
22b. SIGNATURE DEGREE															IN DATE SIGNED 12/29/95						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>																
ALBERT H. GROCHMAN MD		1106 SPRING ST SILVER SPRING MD																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln			23d. LOCATION CITY OR TOWN			COUNTY			STATE							
BURIAL		DEC. 29 1986			Bladensburg Rd.			P. G. Co.													
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE																
Albert T. Tally		In JAN 6 1986			John Wilson-Pender																
Takoma Funeral Home.																					
254 Carroll St. N. W. D. C.																					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having any injury, or other traumatic event, the medical examiner must be notified at once.



360020

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3 5 3 5 2 3 3

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR							
				<b>Walter H. Saalfield</b>	<b>December 17, 1985</b>			<b>P 2:30 M</b>								
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS							
<b>Male</b>		<b>Caucasian</b>		<b>July 3, 1897</b>		<b>88</b>			IF UNDER 24 HRS HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (GIVE INDUSTRY, TRADE, PROFESSION, OR WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
<b>New York</b>		<b>United States</b>				<b>Montgomery County</b>			<b>Olney</b>		<b>Montgomery General Hospital</b>		<b>Buildings Manager</b>		<b>U.S. Government</b>	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE		13f. ZIP CODE		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
<b>Maryland</b>		<b>Montgomery</b>		<b>Silver Spring</b>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<b>15121 Vantage Hill Road</b>		<b>20906</b>		<b>Oscar</b>		<b>Blanche Milks</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (1a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		577-60-5035		Virginia M. Saalfield, same as #13					congestive Heart failure							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I (the hospital) attended the deceased from saw the deceased alive on		12-17-1985		to		12-17-1985		that (I) (we) last viewed the body after death.								
22b. SIGNATURE				DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME		22e. ADDRESS														
<b>BG. Maryland</b>		<b>17904 Georgia Ave Olney, MD 20832</b>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE						
Cremation		Dec 18, 1985		Metropolitan Crem.		Alexandria										
24. FUNERAL DIRECTOR NAME		Robert A. Pumphrey Funeral Homes 7557 Wisconsin Ave. Bethesda, MD 20814 PA		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been issued by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then stamp or initial on the permit: "Burial Permit Issued by State Dept. of Health and Mental Hygiene prior to [initials] [date]" or "Burial Permit Issued by [name] [initials] on [date]" or "Burial Permit Issued by [name] [initials] on [date]".

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

630000



THE ATTENDING PHYSICIAN

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached (or sent to the burial/cremation parent). Then please remove carbon copies. Page 1 and 2 may be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

#16, FilmG611 1/14/86 kam

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Elizabeth S. Sale			2d. DATE OF DEATH Dec. 28 1985	MONTH YEAR 2b. HOUR 5:45 A.M.
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR Apr. 7 1907	6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fairland Nursing Home</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher Retired</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Schools</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Silver Spring</b>
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1300 Peaceful Lane 20902</b>			
14. FATHER'S NAME FIRST <b>Thomas</b>	MIDDLE <b>Stovall</b>	LAST	15. MOTHER'S MAIDEN NAME FIRST <b>Elizabeth</b>	MIDDLE <b>Miller</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N/A</b>	16b. SOCIAL SECURITY NUMBER <b>763-95-577-20-9156</b>	16c. ADDRESS <b>Lyman Sale-son-6700 5th. St., N.W. DC 20012</b>	17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Colon - metastases</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) <input type="checkbox"/> hospital attended the deceased from <b>11-11 1985</b> to <b>12-28 1985</b> , that (I) <input type="checkbox"/> last saw the deceased alive on <b>12-7 1985</b> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated <b>Mortar Altchukovs.</b>				
22b. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>12/28/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mortar Altchukovs.</b>		22e. ADDRESS <b>1298 Chan Center Dr Silver Spring MD 20902</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>1-4-1986</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Baptist Church Cemetery</b>	23d. LOCATION CITY OR TOWN <b>Martin</b>	23e. COUNTY STATE <b>Stephens Georgia</b>
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi Funeral Home</b>	25a. ADDRESS <b>Silver Spring, Md.</b>	25b. DATE REC'D. BY REGISTRAR <b>DEC 31 1985</b>	25c. REGISTRAR'S SIGNATURE <b>John Rinaldi</b>	



353182

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL, IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRUST DEPOSIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PINESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												35285								
												REG. NO.								
1- STATE REGISTRAR			2a DATE KNOWN OF ESTI- DEATH MATED									2b HOUR								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			<input checked="" type="checkbox"/> MONTH DAY YEAR	12 11 19 85	0700 M						
SIDNEY									SALZMAN			<input checked="" type="checkbox"/>								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR		2d. DATE REC'D. BY REGISTRAR NAME ADDRESS		2e. DATE REC'D. BY REGISTRAR'S SUPERVISOR NAME ADDRESS		
Male		Cauc.		11 11 12			73 yrs.							12 11 19 85		0700 M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		11. KIND OF BUSINESS OR INDUSTRY								
New York		USA		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			MONTGOMERY			Technician (Ret.)		Lab. Electronics								
12. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
BETHESDA			5304 Sangamore Road									Technician (Ret.)			Lab. Electronics					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			14. FATHER'S NAME					
N.J.			Ocean			Lakewood			<input checked="" type="checkbox"/> NO <input type="checkbox"/>			1063A Fife Ct (08701)			Samuel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input type="checkbox"/> NO			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS			15. MOTHER'S MAIDEN NAME					
			093-14-0808			Frances Salzman;			ASPHYXIA			Lakewood, N.J.			Esther					
																		Solnitsky		
																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
																		ACUTE		
																		ACUTE		
																		ACUTE		
																		INDEX		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).												CARCINOMA OF PROSTATE								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20 AUTOPSY?								
												<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC)			21e. LOCATION STREET								
			11 11 19 85			HANGING FROM DOOR			5304 SANGAMORE DR BETHESDA MONT MD											
21f. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21g. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC)			21h. LOCATION STREET			21i. CITY OR TOWN			21j. COUNTY			21k. STATE					
			HOME																	
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE			TITLE (SPECIFY)									M.D. <i>Francis C. Mayle</i>			MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS <i>600 W. 36TH ST. NEW YORK, NY 10018</i>									DATE SIGNED <i>12/11/85</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE					
Burial			12/15/85			Mt. Lebanon Cemetery			Iselin, New Jersey											
24. FUNERAL DIRECTOR NAME <i>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</i>			ADDRESS <i>1170 Rockville Pike; Rockville, Md. 20852</i>			25a. DATE REC'D. BY REGISTRAR NAME <i>DEC 6 1985</i>			25b. REGISTRAR'S SIGNATURE <i>Guardian of the Dead</i>											



**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

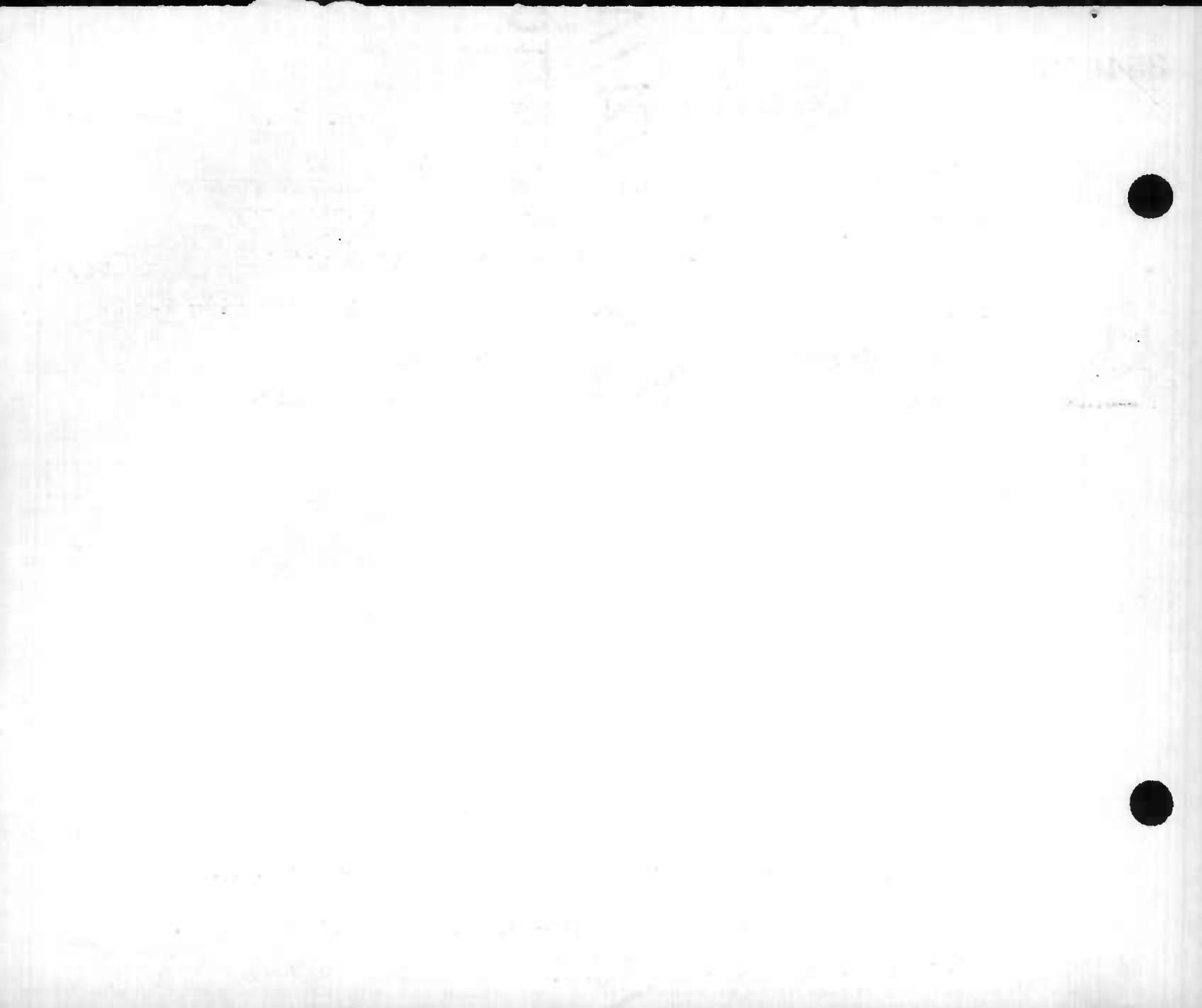
1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

35280

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Elizabeth Dyer Gregg Sayre</b>				FIRST MIDDLE LAST	2a. DATE OF DEATH Dec. 18, 1985	MONTH YEAR	DAY	YEAR	2b. HOUR 4:55 M
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 27, 1903</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b>	IF UNDER 1 YEAR MONTHS <b>YRS.</b>	IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE COUNTRY <b>Oregon</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>						
10. CITY OR TOWN OF DEATH <b>Olney</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>	12. OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Information Specialist</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>CIA</b>						
13a. STATE <b>Md.</b>	13b. COUNTY <b>Mont.</b>	13c. CITY OR TOWN <b>Germantown</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>14909 Spring Meadows Dr</b>					
14. FATHER'S NAME FIRST <b>Unobtainable</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Unobtainable</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NONE</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578 48 1563</b>	17. INFORMANT <b>John A. Gregg (Son) Same as 13E</b>	ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of liver =</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) <i>widespread metastases</i>							2 years		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>a terminal respiratory failure</i>							two		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>4/15</u> , 19 <u>77</u> , to <u>17 Dec</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>17/12/84</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour from the causes stated above, (I) (we) (did) (did not) view the body after death.									22c. DATE SIGNED <u>12/18/85</u>
22b. SIGNATURE <i>Gustavo S Belaval</i>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Gustavo S. Belaval</b>		22e. ADDRESS <b>3701 Rossmoor Blvd. S.S.Md. 20906</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/20/85</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Arlington, Va.</b>	23e. COUNTY STATE			
24. FUNERAL DIRECTOR <b>Hines/Rinaldi</b>		ADDRESS <b>11800 New Hampshire Ave Silver Spring, Md.</b>	25a. DATE REC'D. BY REGISTRAR <b>DEC 18 1985</b>		25b. REGISTRATION NUMBER <b>1234567890</b>				



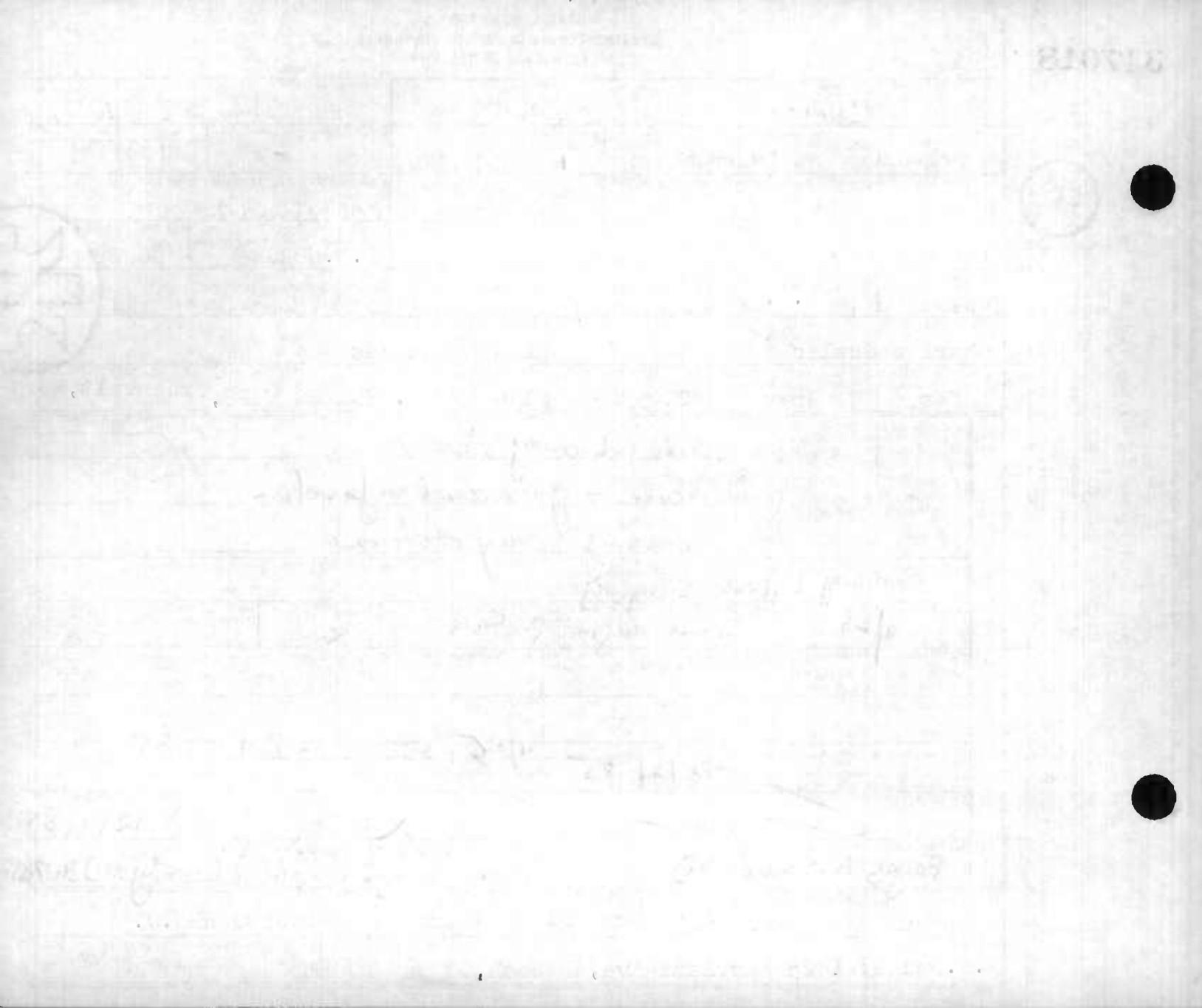
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed in the medical examiner's office with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 5 2 8 /						
1 - STATE REGISTRAR												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2d. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
CHARLES									SCALES			12 3 85		1042	AM			
3 SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.				
MALE			BLACK			MONTH 1 DAY 24 YEAR 30			55 YRS			MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
North Carolina			US						Montgomery									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Takoma Park			Washington Adventist			L.P.NURSE			NONE									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
Maryland			P.G.			Greenbelt			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			8587 Greenbelt Road 20770						
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME									
Charlie Scales									Laura Scales									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			R.D.						
Yes Army			722053098			IMOGENE D. SCALES WIFE,			8587 Greenbelt, Greenbelt, MD									
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute myocardial infarction</u>																		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u>																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Coronary bypass Surgery</u>																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
11/26			Scissure aergina Pectosis			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>11/25/1985</u> , to <u>12/13/1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on <u>12/13/1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED						
22b. SIGNATURE <u>Fayez A. Shawl MD</u>												22d. DEGREE						
22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED															
22f. ADDRESS <u>Du. of Cardiology</u> <u>Princess George Hospital, Cheverly MD 20785</u>			22g. DATE REC'D. BY REGISTRAR															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE				
Burial			Dec/8/85			Dry Hollow Church			Walkertown N.C.									
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
E.M. Dudley 1425 Maryland Ave, NE Wash, DC						DEC 11 1985			<u>S. Anderson Pendleton</u>									



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, AND 3. RETAIN A COPY OF YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												35285		
												REG. NO.		
1- STATE REGISTRAR			2a. DATE KNOWN <input checked="" type="checkbox"/> OF EST. DEATH MATED <input type="checkbox"/>									MONTH DAY YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			12/10/1985	M	
Frederick Edwin Bentley Schanno														
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR		7:54 P.M.
Male		Caucasian		Sept. 19, 85				2 21				12/10/1985		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)								Montgomery County, MD
Maryland		U.S.A.				N/A								
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring		Holy Cross Hospital												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		
Maryland		Montgomery		Kensington		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10116 Crestwood Rd. 20895		Joseph F.		Jo-Anna B.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		ADDRESS		19. DATE OF OPERATION		20. AUTOPSY?		
no						IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				DUE TO, OR AS A CONSEQUENCE OF										
{ (b)				DUE TO, OR AS A CONSEQUENCE OF										
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		20. AUTOPSY?								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										
ACTUAL SIGNATURE <i>[Signature]</i>														
EXAMINER'S NAME (TYPE OR PRINT)		Gregory R. Kauffman, M.D.		ADDRESS		111 Penn St.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE				
Burial		Dec. 13, 85		Gate of Heaven		Silver Spring Mont. Maryland								
24. FUNERAL DIRECTOR NAME		Francis J. Collins, Jr.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
500 Univ. Blvd. W., Silver Spring, Md. 20901				DEC 19 1985		<i>[Signature]</i>								

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*Journal of Clinical Endocrinology and Metabolism*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
REG. NO. 002168 8 5 3 5 2 8 1														
1. FOR STATE REGISTRAR			2. DECEASED NAME (TYPE OR PRINT)			FIRST Sarah			LAST Schaperow			20. DATE OF DEATH Dec 25 1985		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH JAN. 17, 1899			6. AGE (IN YEARS LAST BIRTHDAY) 86			26. HOUR 8:45 AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CONN.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
10. CITY OR TOWN OF DEATH ROCKVILLE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASHINGTON			12a. USUAL OCCUPATION BILLING CLERK			12b. KIND OF BUSINESS OR INDUSTRY DRESS STORE					
13a. STATE MARYLAND			13b. COUNTY PRINCE GEORGES			13c. CITY OR TOWN -ADELPHI			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE (20783) 9809 26th Ave. Adelphi, Md.		
14. FATHER'S NAME FIRST HARRIS			MIDDLE KROOPNICK			15. MOTHER'S MAIDEN NAME FIRST ANNA			LAST SHEMONSKY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 041-32-0601			17. INFORMANT Mrs. Elaine Kelley			ADDRESS (20783) 9809 26th Ave Adelphi, Md.					
18. CAUSE OF DEATH: (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost														
DUE TO, OR AS A CONSEQUENCE OF (b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>chronic renal failure congestive heart failure</i>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 23</u> , 19 <u>85</u> , to <u>Dec 25</u> , 19 <u>85</u> , that (I) <input checked="" type="checkbox"/> we lost the deceased alive on <u>Dec 23</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> we did <input type="checkbox"/> did not view the body after death.														
22b. SIGN <u>Mark S Rosen, MD</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/25/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Mark S Rosen, MD</u>			22e. ADDRESS <u>Silver Spring, MD</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL / BURIAL			23b. DATE DEC. 27, 1985			23c. NAME OF CEMETERY OR CREMATORIAL NORTHWOOD CEM.			23d. LOCATION CITY OR TOWN WILSON, CONN.			COUNTY STATE		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS, 6010 REISTERSTOWN RD. BALTO., MD. (21215)			25a. DATE REC'D. BY REGISTRAR DEC 30 1985			25b. REGISTRAR'S SIGNATURE <u>Jane Levinson Pendleton</u>								

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove both pages 1 and 2 should be filed within 24 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												5 35290					
												REG. NO.					
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
			FRED E.			SCAMIDT			DEC. 24, 1985			2:00 P.M.					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.							
Male		Caucasian		April 13 1891			94 YRS.										
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
Kansas		USA.					Montgomery										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSP										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
Rockville												Credit Reporter			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS							
California		Orange		Huntington BEACH			<input type="checkbox"/> NO <input checked="" type="checkbox"/>			17351 Frans Lane 99999							
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
Edward Schmidt			Anna O'Brien														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 490 09 2486			17. INFORMANT			ADDRESS								
						Charles Schmidt (son)			Gaithersburg, Md.								
									20901 Goshen Road			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cards respiratory arrest</u>																	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u>																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Cerebrovascular accident</u>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 24, 1985</u> , to <u>Dec. 24, 1985</u> , that (I) (we) last saw the deceased alive on <u>Dec 24, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) find (and state) now the body after death.																	
22b. SIGNATURE <u>Fred E. Schmidt</u>		22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>Dec. 24, 1985</u>									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Kwang S. Kim</u>		22f. ADDRESS 50 W. Edmondson Dr. Rockville, MD.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <input type="checkbox"/> Burial		23b. DATE <u>Dec 30, 1985</u>			23c. NAME OF CEMETERY OR CREMATORIAL Floral Hills Cemetery			23d. LOCATION CITY OR TOWN Kansas City		COUNTY	STATE						
24. FUNERAL DIRECTOR NAME Ives-Pearson Funeral Homes, Arlington, VA								25a. DATE REC'D. BY REGISTRAR <u>JAN 3 1986</u>		25b. REGISTRAR'S SIGNATURE <u>Ives-Pearson</u>							

SECOND



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be retained for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 5 3 5 2 9 1			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
JACKIE			R.	SCHRIVER		12 9 85			246	AM			
3. SEX			4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS		
MALE			CAU	MONTH 8 DAY 10 YEAR 24	61			MONTHS	DAYS		HOURS	MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			Montgomery MD.			
Maryland			USA										
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Takoma Park			WASH. ADVENTIST HOSP			Mechanic			Automatic Doors				
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Maryland			Montgomery	Silver Spring	YES <input type="checkbox"/> NO <input type="checkbox"/>			2201 Norbeck Road 20906					
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	ADDRESS			
George			R.	Schrivier	Cora			Kerns					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Yes			WW II			579-16-7540 Georgia P. Schrивier Wife Same as 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST													
DUE TO, OR AS A CONSEQUENCE OF (b) ADENOCARCINOMA OF LUNG													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) CVA													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from August 1985, to December 9, 1985, that (I) (we) last saw the deceased alive on November 24, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Pamela P. Zarick			DEGREE MD.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/9/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAMELA P. ZARICK			22e. ADDRESS 501 N. FREDERICK AVE. GAITHERSBURG, MD.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 12, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Maryland Veteran's			23d. LOCATION CITY OR TOWN Cheltenham Pk.			COUNTY	STATE
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.			25. DEATH REGULARLY RECEIVED BY REGISTRAR'S SIGNATURE 500 University Blvd. W. Silver Spring, Md.			DEC 13 1985							

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN READING ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3, RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, Cremation, or Removal.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 35292	
1- STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE KNOWN TO MONTH DAY YEAR	
Elbert Louis Schultz												Dec 10 1985	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2b HOUR	
M		W		Aug 31 1962 23		YRS.						M	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			2c DATE PRONOUNCED DEAD MONTH DAY YEAR	
Germany			USA									Dec 10 1985	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Si. L. Spg			3020 Bed Pk Rd Ap 302									12b KIND OF BUSINESS OR INDUSTRY	
13a STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS	
Md			Montgomery									3020 Bed Pk Rd Ap 302	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
PAUL ALFRED SCHULTZ			VERA KELLENBERGER										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b SOCIAL SECURITY NO.									17. INFORMANT ADDRESS	
NO												VERA SCHULTZ, SAME AS ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Guns hot wound of heart</i>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>None</i>													
19a. DATE OF OPERATION <i>None</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR P.M. 12/10/85			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) <i>Shot so 1F</i>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i>			21f. LOCATION STREET <i>Bell Park St</i> , CITY OR TOWN <i>Catonsville</i> , COUNTY <i>Montgomery</i> , STATE <i>Md</i>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>John S. Rogers</i> M.D. <i>John S. Rogers</i> MEDICAL EXAMINER EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS ADDRESS													DATE <i>Dec 10 1985</i>
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)			23b. DATE <i>12/10/85</i>			23c. NAME OF CEMETERY OR CREMATORIUM <i>Westview Mem. Park</i>			23d. LOCATION CITY OR TOWN <i>Catonsville</i> , COUNTY <i>Md</i>				
24. FUNERAL DIRECTOR NAME <i>DONALDSON FUNERAL HOME</i> , ADDRESS <i>Laurel</i>									25a. DATE REC'D. BY REGISTRAR <i>DEC 18 1985</i>			25b. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>	
DPH - 17 (VR A15 ME (5))													

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W. A.

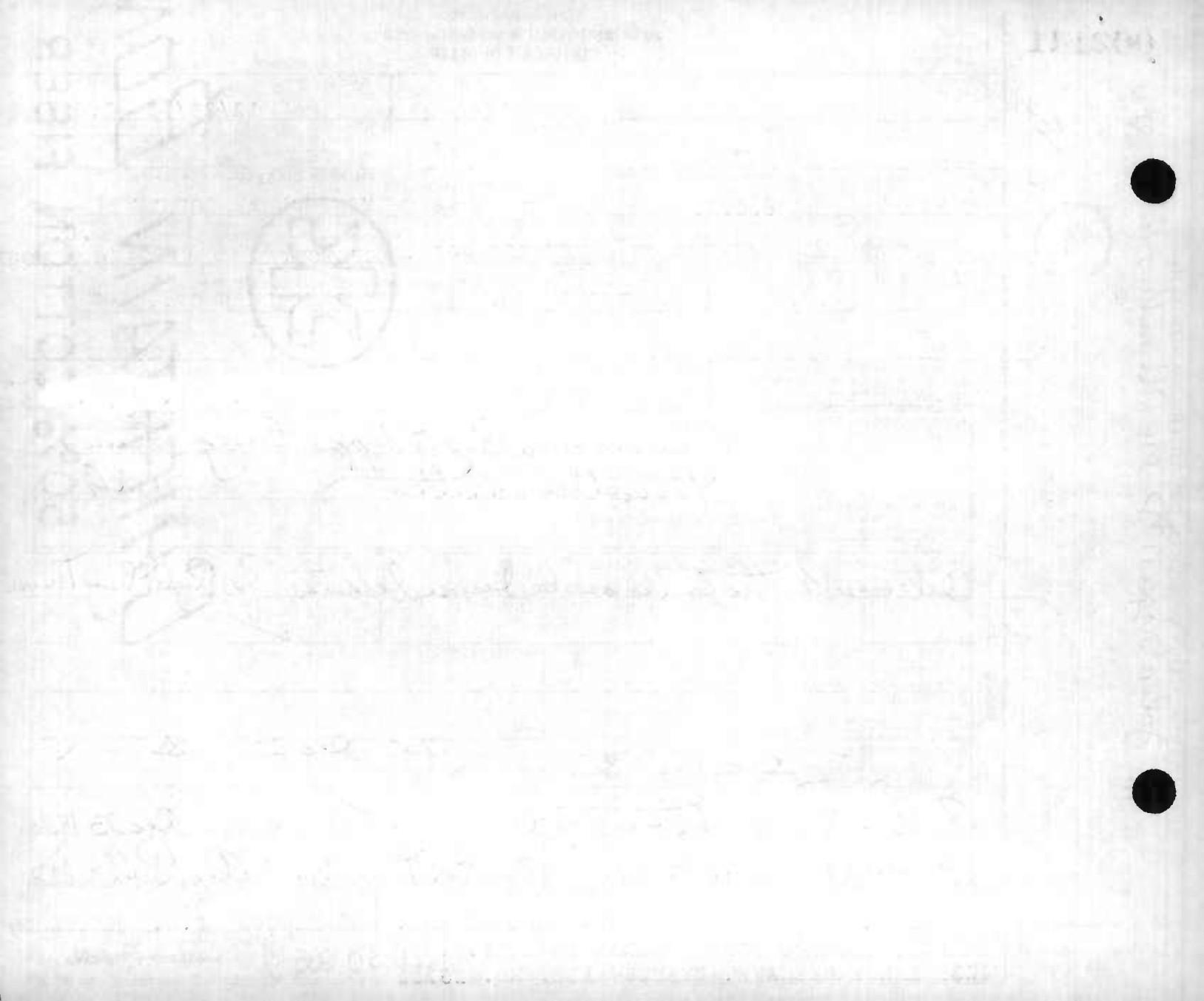
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*John Rogers MD*  
TO HOSPITAL OR ATTENDING PHYSICIAN. The physician that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
REG. NO. 8535293													
1 - FOR STATE REGISTRAR			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
1 DECEASED NAME (TYPE OR PRINT)			GARDNER	WILLIAM	SCOTT	12/23/85				8:02 p.m.			
3 SEX			4 RACE	5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
MALE			WHITE	MONTH	DAY	YEAR	80						
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH				
TEXAS			U.S.A.						MONTGOMERY COUNTY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
TAKOMA PARK, MD			WASHINGTON ADVENTIST HOSP.			CUSTODIAN			D.C. PUBLIC SCHOOL				
13a STATE MD			13b COUNTY P.G.			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 3401 SHEPERD ST., 20712				
14 FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	ADDRESS			
RUBEN			GREENWOOD	SCOTT	SALLIE					GARDNER			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			18a CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				
YES-PEACETIME			578-36-8592			(Daughter) 4811 Boiling Brook Ct. Mary Himmelfarb Rockville, Md. 20852			COPD, Pneumonia Right Upper Lung Inflammation Sensitivities				
18b DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVING RISE TO DEATH <i>External Cervical Arterial Disease, Diabetes, Post Polio Syndrome</i>													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			19c AUTOPSY			20a IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a I certify that (1) this hospital attended the deceased from <u>Dec 16 1985</u> to <u>Dec 23 1985</u> , that (2) he/she was alive on <u>Dec 16 1985</u> , and that in my ( <u>my</u> ) opinion death occurred on the date and hour and from the causes stated above, (I <input checked="" type="checkbox"/> did) <input type="checkbox"/> did not view the body after death.													
22b SIGNATURE <i>Richard L. Welleton MD</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED <u>Dec 23 1985</u>				
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>RICHARD L. WELTON</i>			22e ADDRESS <i>7100 Baltimore Ave College Park MD</i>										
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE 12/27/85			23c NAME OF CEMETERY OR CREMATORIAL FORT LINCOLN CEM.			23d LOCATION CITY OR TOWN BRENTWOOD P.G. MARYLAND				
24 FUNERAL DIRECTOR FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 BALTIMORE AVE. HYATTSVILLE, MD. 20781						25a DATE REC'D. BY REGISTRAR DEC 30 1985			25b REGISTRAR'S SIGNATURE <i>Jane Davidson-Pender</i>				



365170

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 35294

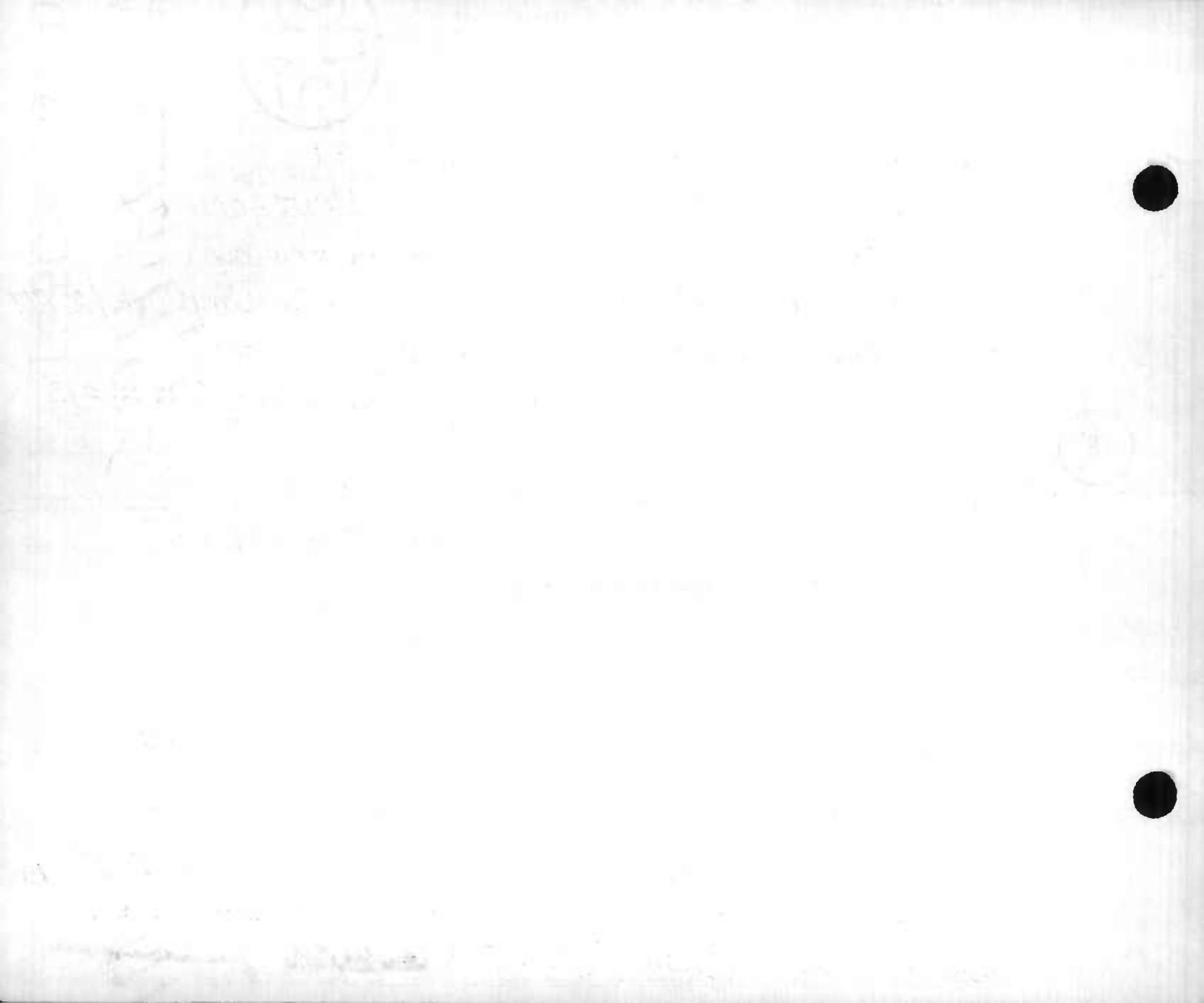
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be completed filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

IMPORTANT: If Item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified of one.

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Macey A. Scott						12-11-85				23 30	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Black		JAN 10, 1904		81		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
MD		USA				MONTGOMERY					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Rockville			Shady Grove Adventist Hospital			Housewife					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS / ZIP CODE		
			MD			Gaithersburg			7919 Spiceberry Circle / 20877		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Tom Williams			Macey Williams								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No						Dorothy Craven (Daughter) SAME AS #13					
18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPERTENSION / s/p CVA &amp; Hemiparesis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Diabetes Mellitus Insulin Dependent</u>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>GIP, CVA &amp; Hemiparesis (e)</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
None					YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Hector Asuncion MD</u>			22c. DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>12-12-85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS 18730 Germantown Road, Germantown, MD 20874						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 12-18-85		23c. NAME OF CEMETERY OR CREMATORIUM Warren Cemetery		23d. LOCATION Martinsburg, Montg. MD					
24. FUNERAL DIRECTOR NAME		246 N. Washington Street Rockville, MD 20850			25a. DATE REC'D. BY REGISTRAR <u>DEC 20 1985</u>		25b. REGISTRAR'S SIGNATURE <u>George R. Snowden</u>				



365189

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

85 35295

1 -  
FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST WILLIAM	MIDDLE SEFF	LAST SEFF	20. DATE OF DEATH MONTH DAY YEAR	21. HOUR 12/20/85 2:55 PM
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5/12/80</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b>	
10. CITY OR TOWN OF DEATH <b>ROCKVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HEBREW HOME OF GREATER WASHINGTON</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BROKER</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>REAL ESTATE</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>ROCKVILLE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>6121 MONTROSE ROAD 20852</b>	MD.
14. FATHER'S NAME FIRST <b>SAMUEL</b>		MIDDLE	LAST <b>SEFF</b>	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST <b>UNKNOWN</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-07-5408</b>		17. INFORMANT (DAUGHTER) ADDRESS <b>SUZANE KUFF, 6020 DELLWOOD PL., BETHESDA, MD.</b>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 YEARS</b>	
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<b>CEREBRAL ARTERIOSCLEROSIS</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) <b>GENERALIZED ARTERIOSCLEROSIS 5 YEARS</b>				
		DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b>PARKINSON'S DISEASE</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 19, 85</b> to <b>DEC 20, 85</b> , that (I) (we) last saw the deceased alive on <b>DEC 20, 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Steven Lipson M.D.</i>		DEGREE M.D.	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>12/20/85</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEVEN LIPSON</b>		22e. ADDRESS <b>6121 MONTROSE RD, ROCKVILLE</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>12/21/85</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>METROPOLITAN CREMATORIAL</b>	23d. LOCATION CITY OR TOWN <b>ALEXANDRIA, VIRGINIA</b>		
24. FUNERAL DIRECTOR NAME <b>RICHARD RAPP, INC.</b>		ADDRESS <b>1804 T ST., N.W., WASHINGTON, D.C. 20009</b>	25a. DATE REC'D. BY REGISTRAR <b>DEC 23 1985</b>	25b. REGISTRAR'S SIGNATURE <i>Juli Twidley-Bordas</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. Enter 3

3. FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, Enter 3  
should be detached for use at the burial/transit parlor. Then please remove this page. If pages 1 and 2 should be filed within 72 hours after death  
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

referred by the hospital or attending physician.

3. FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, Enter 3  
should be detached for use at the burial/transit parlor. Then please remove this page. If pages 1 and 2 should be filed within 72 hours after death  
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 35290

1 DECEASED NAME FIRST MIDDLE LAST				2a DATE OF DEATH MONTH DAY YEAR	2b HOUR
Samuel Seifert				December 30, 1985	4:58 PM
3. SEX male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> EVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	79	YRS	
10 CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Production-Manager; Food Indust.	
13a STATE Maryland	13b COUNTY Montgomery	13c CITY OR TOWN Silver Spring	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 3402 Chiswick Court, #1D (20906)	
14. FATHER'S NAME FIRST MIDDLE LAST	15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
David	Seifert Hannah Singer			ADDRESS D.C. 20003	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b SOCIAL SECURITY NO. -----	17 INFORMANT			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Failure + Cardiac Arrest APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24h					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia RL lung + COPD. 3 days.					
(c) Cancer RL lung metastatic to liver & spine 2 weeks.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a ASHD, Arteriosclerotic Peripheral Vascular Disease, Spinal Stenosis					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED	(ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a I certify that (I) (the hospital) attended the deceased from 12/20 1985 to 12/30 1985, that (we) last saw the deceased alive on 12/30 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Dr. Lawless	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 12/30/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Lawless	22e ADDRESS 18111 Prince Philip Drive; Olney, Maryland				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/2/86	23c NAME OF CEMETERY OR CREMATORIAL Judean Memorial Gdns.	23d LOCATION CITY OR TOWN Olney; Montgomery; Maryland	23e COUNTY	23f STATE
24 FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852	25a DATE REC'D. BY REGISTRAR JAN 3 1986			25b REGISTRAR'S SIGNATURE Julia Davidson Pendall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this document be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the medical examiner with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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354094

ITEM NUMBER 13e, PER PH. CALL STATE OF MARYLAND  
12-23-85 D.W.DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

85 35291

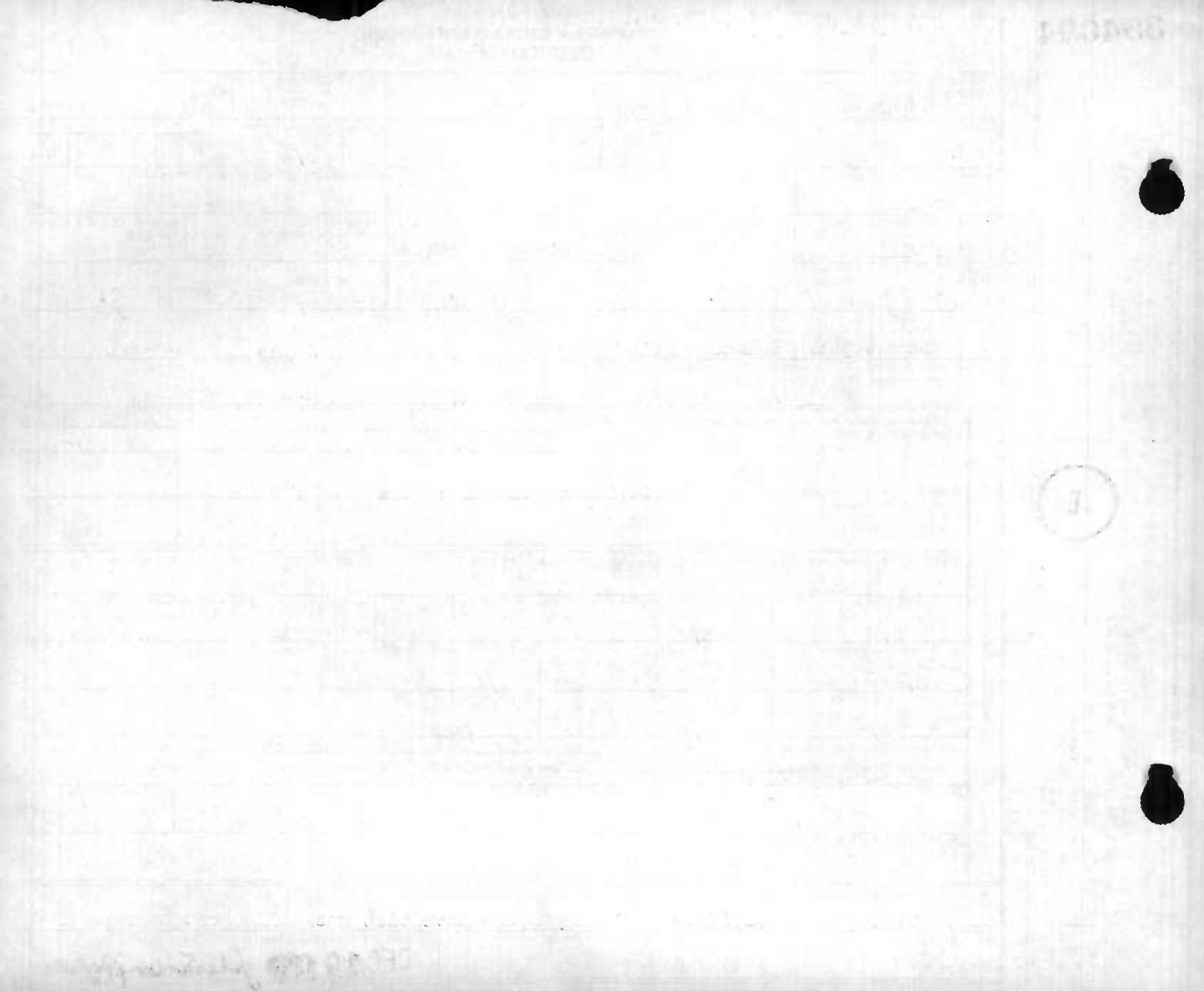
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then place page 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or if item 18 shows any injury or other significant condition contributing to death, the medical committee of the Board of Health and Mental Hygiene prior to burial/cremation, removal.

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Anthony Montgomery Selby						December 17 <sup>th</sup> , 1985				0450 A.M.
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS	
MALE		white	12	17	85	N/A	YRS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> N/A DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Maryland		N/A				Montgomery				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Rockville		Shady Grove Adventist Hospital			N/A			N/A		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE	
N/A MD		N/A MONT.	N/A						269 N. VERNON BUREN ST. 20850	
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	ADDRESS	
Christopher Roland			Selby	Tammetha			Joyce		Mullins	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
N/A		N/A			264 N. Van Buren Street, Rockville, MD 20850			44 min		
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and 1(c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Preaturity										
DUE TO, OR AS A CONSEQUENCE OF (b) Partial Abruptio Placentae										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) N/A										
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> N/A NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, MARK MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) N/A					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> N/A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) N/A			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12-17-85 to 12-17-85, that (I) (we) last saw the deceased alive on 12-17-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.										
22b. SIGNATURE Robert Ducek MD		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 12-17-85		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Ducek MD		22f. ADDRESS Shady Grove Hosp. Rockville MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1/17/86		23c. NAME OF CEMETERY OR CREMATORY Shady Grove Adventist Hospital		23d. LOCATION CITY OR TOWN Rockville Montgomery		23e. COUNTY MD		
24. FUNERAL DIRECTOR NAME N/A		ADDRESS			25a. DATE REC'D. BY REGISTRAR DEC 18 1985			25b. REGISTRAR'S SIGNATURE John T. Wilson, Jr.		
DHMH - 16 50M 4/83 (VRA 15, 4)										



006052

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

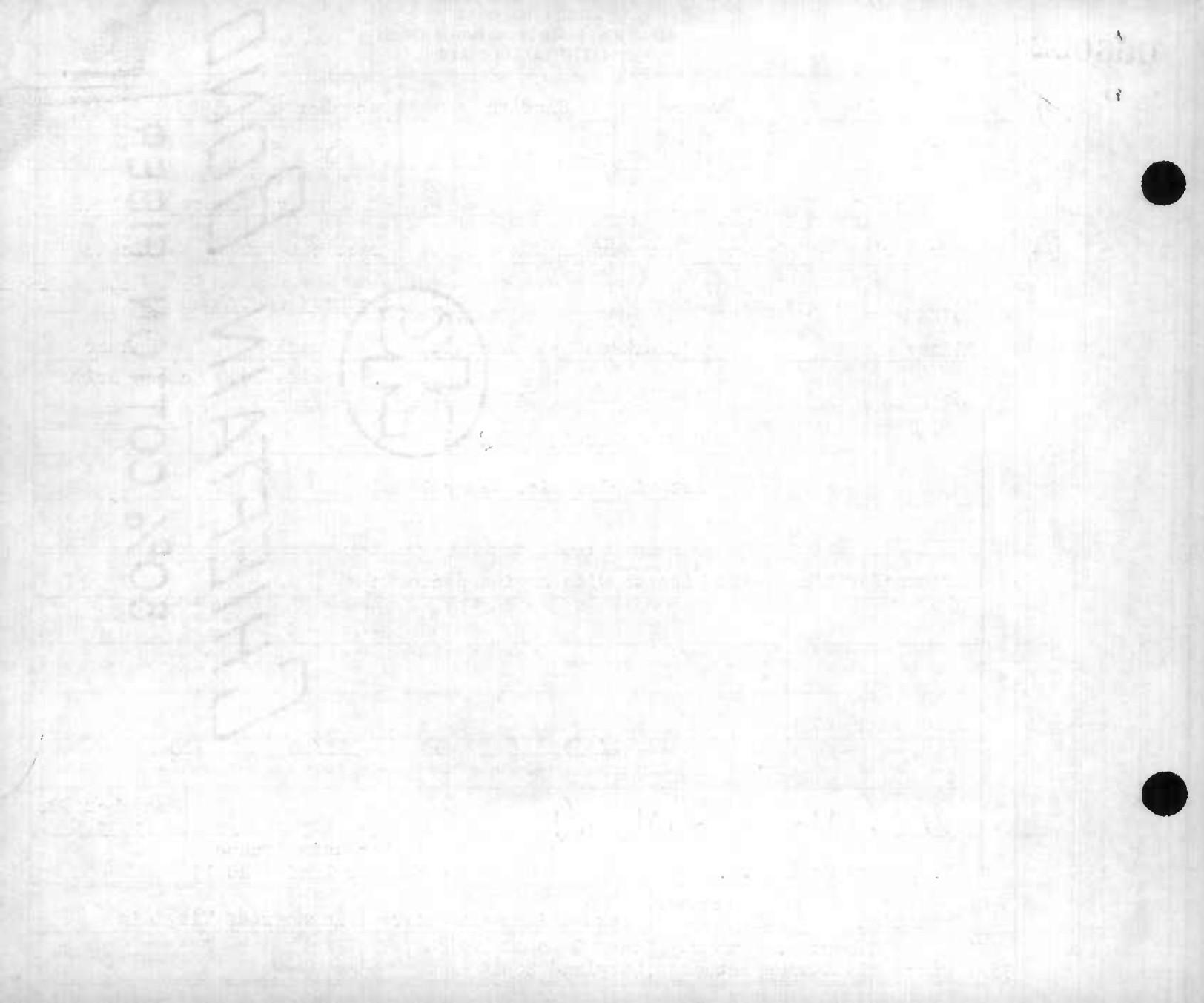
8 5 3 5 2 9 8

1. DECEASED NAME FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR	
Elsie Irene Sharits			December 30, 1985	5PM M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Female	Caucasian	June 10, 1892	93 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Peabody Kansas	United States		Montgomery County Maryland MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	Sylvan Manor Nursing Home			Practical Nurse	Medicine
13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? Maryland Montgomery Bethesda YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
13e. STREET ADDRESS / ZIP CODE 5600 McLean Drive Bethesda, Maryland 20814					
14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Sidney Bryant Clarkson	Amoretta Pearl Palmer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
No	513-22-3181	Earl C. Sharits 5600 McLean Drive Bethesda, Maryland 20814			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Brain Syndrome					
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis, Generalized					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arterosclerotic Heart Disease with angina pectoris					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 7/5/79, 19 79, to 12/30, 19 85, that (I) (we) last saw the deceased alive on 12/23, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>W. Luther Hall M.D.</i>					
22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. ADDRESS 6000 Wisconsin Avenue Chevy Chase, Maryland 20815					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE December 31, 1985	23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory	23d. LOCATION CITY OR TOWN Alexandria, Virginia	22e. COUNTY STATE	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes PA ADDRESS 7557 Wisconsin Avenue Bethesda, Maryland 20814	25a. DATE REC'D. BY REGISTRAR JAN 02 1986			25b. REGISTRAR'S SIGNATURE <i>Jane L. [Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

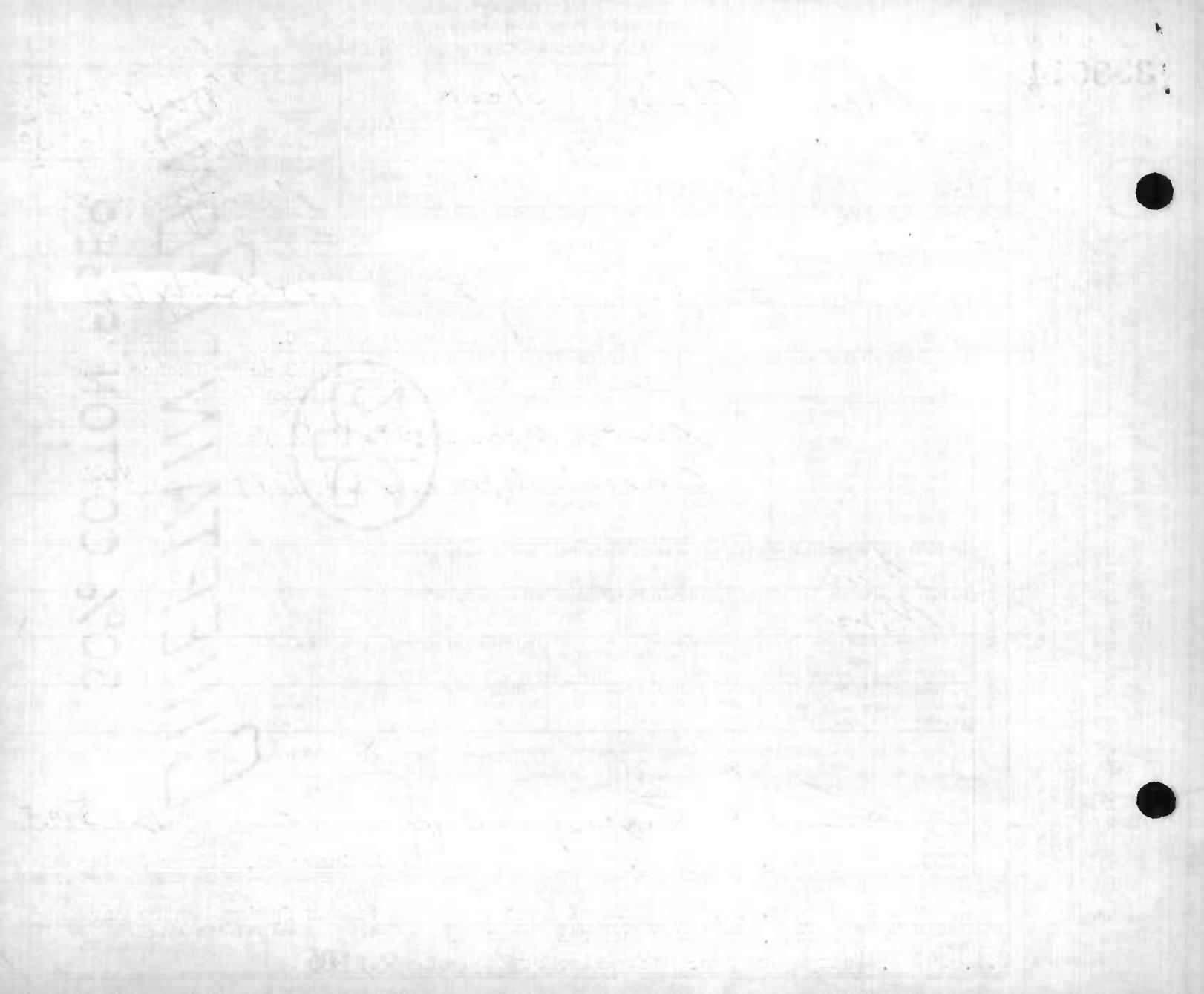
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Page 2 will be filled in at the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR FILES.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 35294	
1- STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. MONTH DAY YEAR				
<i>Mary</i>			<i>Clarie Sheek</i>			Dec 15 1985			8:56 AM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS			
Female		Caucasian		Aug 30, 1948		37 RS.		MONTH DAYS		HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		2c. DATE PRONOUNCED DEAD		2d. MONTH DAY YEAR			
Michigan		United States				Montgomery		Dec 18 1985		8:50 AM			
10. ID. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Gaithersburg			17645 Amity Drive			Department Manager			Retail				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Maryland		Montgomery		Gaithersburg		YES			17645 Amity Drive				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Eldo			Wiebe Dorothy C. Turner										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			215-52-7241			David Harmer			11613 Happy Choice Lane Gaithersburg, Maryland 20878				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
{ (b) <i>Chronic myocardial Dis.</i> yrs DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
None			None			None			None				
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?							
None						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>John S. Rogers</i> TITLE (SPECIFY) M.D. <i>John S. Rogers</i> MEDICAL EXAMINER													
DATE SIGNED <i>Dec 15 1985</i>													
EXAMINER'S NAME (TYPE OR PRINT)			John S. Rogers MD.			ADDRESS 1919 Seminary Rd, Silver Spring MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial Dec. 18, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven			23d. LOCATION CITY OR TOWN Silver Spring				
24. FUNERAL DIRECTOR NAME			ADDRESS Robert A. Pumphrey Funeral Homes P.A. 300 W. Montgomery Ave. Rockville, Maryland			25a. DATE REC'D. BY REGISTRAR DEC 20 1985			25b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>				
VR A15 ME (5)													
BP													
DHMH - 17													



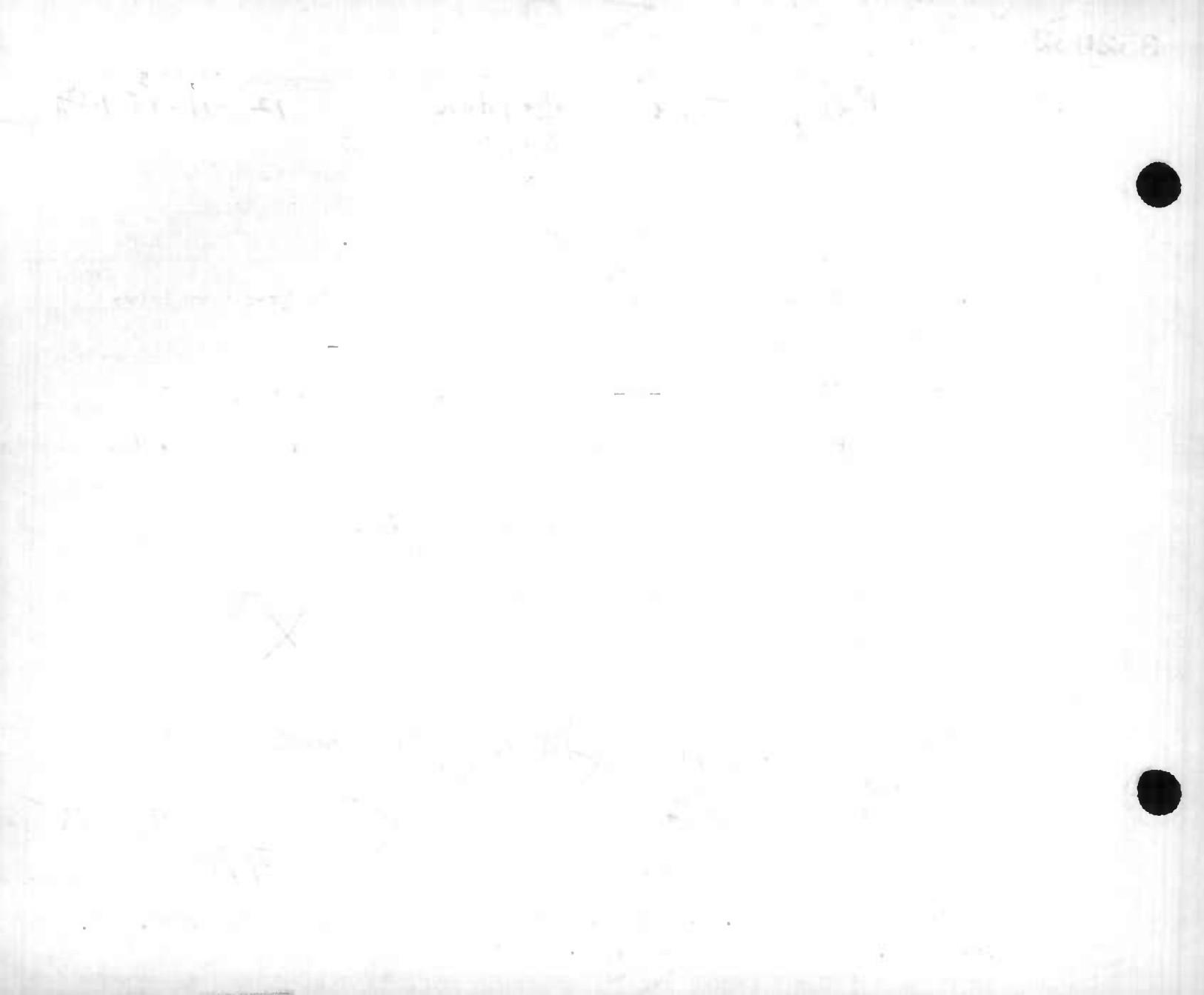
352052

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use on the death-tombel emblem. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 35300	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)	FIRST RUBY	MIDDLE JUNE	LAST SHELDON	2a. DATE DECEASED	MONTH DECEMBER	DAY 11	YEAR 1985	2b. HOUR 12 - 11 - 85	11 1/4 A.M.		
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH JUNE 4, 1922	6. AGE (IN YEARS LAST BIRTHDAY) 63	IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE COUNTRY IDAHO	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.								
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION WASHINGTON ADVENTIST			12a. USUAL OCCUPATION H. MAKER			12b. KIND OF BUSINESS OR INDUSTRY HOME				
13a. STATE MD.	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN ASHTON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 17820 Tree Lawn Drive 20861							
14. FATHER'S NAME FIRST MILLARD	MIDDLE -	LAST KIDD	15. MOTHER'S MAIDEN NAME SELMA	16. SOCIAL SECURITY NO. 519-10-5582		17. INFORMANT GRANT H. SHELDON	ADDRESS Same as # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>hepatitis failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastasis to liver</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>breast cancer</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11h h.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21e. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 11 1985</i> to <i>March 84</i> , to <i>Dec 85</i> , 1985, that (I) (we) last saw the deceased alive on <i>1985</i> and shot in (my) (our) opinion death occurred on the date and hour and from the causes stated (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>Martin Miller</i>				22c. DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED <i>12/11/85</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>7525 Greenway Condo Greenbelt MD 20770</i>	22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE DEC. 14, 1985	23c. NAME OF CEMETERY OR CREMATORIUM LAYTONSVILLE	23d. LOCATION CITY OR TOWN LAYTONSVILLE	23e. COUNTY MONT.	23f. STATE MD.						
24. FUNERAL DIRECTOR FRANCIS H. BARBER	25a. DATE REC'D. BY REGISTRAR LAYTONSVILLE, MD. 20879			25b. REGISTRAR'S SIGNATURE <i>DEC 16 1985</i>							



351147

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 35301

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR			
Robert H. Shuck			December 8, 1985	10 <sup>50</sup> A.M.									
3. SEX			4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)								
Male			Caucasian	9 28 11	74 40								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.		
Maryland			USA				Montgomery County						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			15101 Interlocken Dr.					Clerical			Grocer		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
Maryland			Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		15101 Interlocken Dr. 20906				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.				17. INFORMANT	
Robert			W.	Shuck	Vellie Mae	Klosterman		214 07 1697				Wife Pauline A. Shuck SAME	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.					17. INFORMANT				ADDRESS	
No													
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Metastatic disease												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 months	
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of bladder												16 months	
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
6/14/84			Carcinoma of Bladder					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED  WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		
22a. I certify that (I) (this hospital) attended the deceased from <u>June 4, 1984</u> to <u>present</u> , 19_____, that (I) (we) last saw the deceased alive on <u>11/19/85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE													
22c. DATE SIGNED 12/19/85													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	
Robert L. Flynn MD			5454 Wisconsin Ave Chevy Chase										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		
Burial			Dec. 11, 1985			Frostburg Memorial			Frostburg		Allegany Maryland		
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE					
Francis J. Collins, Jr.								DEC 13 1985					
500 University Blvd. W. Silver Spring, Md.													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

repaired by the hospital or attending physician.

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then place remains in the casket or container and seal it. Fill in page 3 and mail it within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**365163**

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 35302									
										REG. NO.									
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR							
			ANDREW			SILVA			12 12 85			145 PM							
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN							
Male		Asian		Nov. 29, 1903			82 YRS												
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH											
Sri Lanka		Sri Lanka						MONTGOMERY CO MD.											
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY											
SUBURBAN		SUBURBAN HOSPITAL			Architect			Gov't.											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE										
Maryland		Montgomery		Bethesda					7505 Glennon Dr. 20817										
14 FATHER'S NAME FIRST		MIDDLE		LAST		15 MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST								
Caitan				Silva		Veronica					Unknown								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No				None			Jayanganie Ranasinghe Same As 13e												
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>cardiac arrhythmia</i>																			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>severe ischemic cardiomyopathy</i>																			
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>biventricular heart failure w/ pulmonary hypertension; generalized edema</i>																			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN			COUNTY		STATE						
22a I certify that (I) (this hospital) attended the deceased from <i>12/9/85</i> to <i>12/11/85</i> , that (I) (we) lost sow the deceased alive on <i>12/12/85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b SIGNATURE <i>George</i>										DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <i>12-12-85</i>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wilhelmine G. Carrion 70</i>		22e ADDRESS <i>4912 ADRIAN ST Rockville MD 20853</i>																	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 12-16-85		23c NAME OF CEMETERY OR CREMATORIAL Mt. Comfort Crematory			23d LOCATION CITY OR TOWN Alexandria			COUNTY		STATE Va.							
24 FUNERAL DIRECTOR NAME <i>Joseph Gawler's Sons 5130 Wisconsin Ave. N.W.</i>		ADDRESS <i>Wash. D.C.</i>		25a DATE REC'D. BY REGISTRAR <i>DEC 18 1985</i>			25b REGISTRAR'S SIGNATURE <i>John L. Deaderick, Jr.</i>												

23154

100% COTTON FABRIC



352093

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA. 3. RETAIN PAGES 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE USED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 35303						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/>	MONTH	DAY	YEAR	6:00 P.M.		
Leo			John			Simon						12/10	19	85				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD	MONTH DAY		YEAR	6:00 P.M.
Male		White		Feb. 16, 1921			64 yrs.							12/10	19	85		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Pennsylvania		United States												Montgomery County MD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION FOR MOST OF WORKING LIFE		12b. KIND OF BUSINESS OR INDUSTRY				
Wheaton		12109 Edgemont Street										Mech. Sheet Metal		AC & Heating				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		20902						
Maryland		Montgomery		Wheaton						12109 Edgemont Street								
14. FATHER'S NAME FIRST		MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			Kraska							
Stanley					Simon			Helen										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			Wife			ADDRESS								
No		424 03 1695		Elizabeth A. Simon			Same as item 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
IMMEDIATE CAUSE (a) Acute myocardial disease DUE TO, OR AS A CONSEQUENCE OF																		
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																		
(b) chronic myocardial disease and chronic XXXXXX obstructive pulmonary disease.																		
(c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																		
None																		
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			None										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																		
ACTUAL SIGNATURE <i>John S. Rogers</i>		M.D.			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER			DATE SIGNED 12/11/85							
EXAMINER'S NAME (TYPE OR PRINT)		John S. Rogers, M.D.										ADDRESS 1919 Seminary Road Silver Spring, Montgomery County, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial Entombment		23b. DATE Dec. 14, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven			23d. LOCATION CITY OR TOWN Silver Spring, Maryland			COUNTY		STATE					
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOMES NAME P.A. 300 West Montgomery Ave. Rockville, Md.		ADDRESS DEC 16 1985										25. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>						
BP _____																		
DHMH - 17 (VR A15 ME (5))																		

14. Feb 1944

George Washington



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

343064

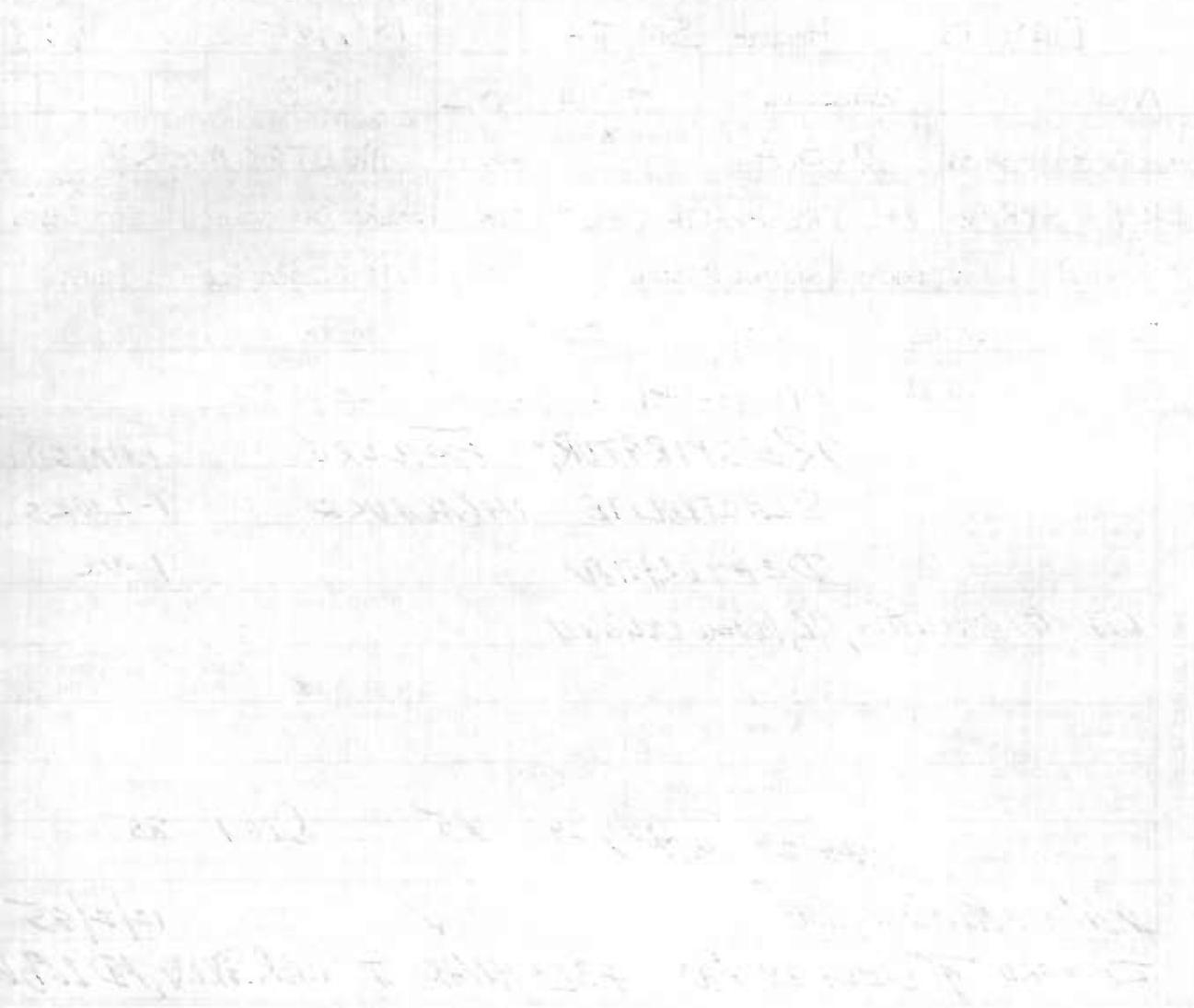
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
<u>DAVID</u>				<u>Howard</u>	<u>SMITH</u>	<u>12/1/85</u>				<u>6:05 PM</u>			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				
<u>Male</u>			<u>caucasion</u>			<u>7</u>	<u>4</u>	<u>02</u>	<u>83</u>	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
<u>NEW HAMPSHIRE</u>			<u>U. S. A.</u>						<u>MONTGOMERY</u>				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
<u>SILVER SPRING</u>			<u>BEL PRE HEALTH CARE CENTER</u>			<u>Purchasing agent</u>			<u>Radio Inst.</u>				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS	
<u>Maryland</u>			<u>Montgomery</u>			<u>Silver Spring</u>						<u>3618 Gleneagles Dr. 20906</u>	
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST
<u>Frank</u>			<u>Drake</u>			<u>Smith</u>			<u>Sallie</u>			<u>Belle</u>	<u>Howard</u>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT (Wife) Ida M. Smith Same as 13e			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<u>Yes</u>			<u>WW II</u>			<u>577-03-6171</u>						<u>1MAD DAY</u>	
18. CAUSE OF DEATH (Enter only one cause per line for part 1a, 1b, and 1c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u>												1-2 WKS	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ELECTROLYTE IMBALANCE</u>												1 wk	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>DEHYDRATION</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Diabetes mellitus, Alzheimer's disease</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 24 1985</u> to <u>Dec 1 1985</u> , that (I) (we) last saw the deceased alive on <u>Aug 24 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <u>12/2/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. ADDRESS				
<u>RICHARD T. DELANEY MD</u>									<u>4323 HARVARD ST SILVER SPRNG, MD 20886</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE
Burial			<u>Dec. 5, 1985</u>			<u>Fort Lincoln</u>			<u>Brentwood</u>			<u>Prin Geo</u>	<u>Maryland</u>
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
<u>Francis J. Collins</u>													
500 University Blvd. W. Silver Spring, Md. 20901													
DEC 5 1985													

13016



361053

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED IN THE 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL. ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSPORT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 35305	
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Herbert</i>	MIDDLE <i>L.</i>	LAST <i>Smith</i>	2a. DATE KNOWN OF ESTI- MATED			MONTH 12	DAY 19	YEAR 85	2b. HOUR 11:15 P.M.	
2c. SEX	2d. RACE	3. DATE OF BIRTH MONTH 6	DAY 16	YEAR 15	4. AGE (IN YEARS LAST BIRTHDAY) YRS. 70	5. IF UNDER 1 YR.	6. IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	MONTH 12	DAY 19	YEAR 85	2d. HOUR 11:13 P.M.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wash., D.C.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i>			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Geographer</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Fed. Gov't.</i>	
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>			13c. CITY OR TOWN <i>Bethesda</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>6601 Hillmead Road 20817</i>			
14. FATHER'S NAME FIRST <i>Herbert</i>			MIDDLE <i>Lee</i>	LAST <i>Smith</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Lora</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>577-14-3285</i>			17. INFORMANT <i>Mildred C Smith. Same as item 13.</i>			ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio respiratory arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary arteriosclerosis</i>													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>John Tauber</i>			TITLE (SPECIFY) <i>M.D. Dept</i>									DATE SIGNED <i>12-20-85</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>John Tauber</i>			MEDICAL EXAMINER									<i>Bette Sola M.D.</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>12/23/1985</i>			23c. NAME OF CEMETERY OR CREMATORIUM <i>Rock Creek Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Washington, D.C.</i>			COUNTY	STATE
24. FUNERAL DIRECTOR NAME <i>Joseph Gawler's Sons Inc.</i>			ADDRESS <i>5130 Wisc. Ave., N.W. Wash., D.C.</i>			25a. DATE REC'D. BY REGISTRAR <i>DEC 24 1985</i>			25b. REGISTRAR'S SIGNATURE <i>John Tauber</i>				
5M 2/80													
DHMH-17 (VR A15 ME(5))													

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## 上文之引言

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• 100% Biodegradable • 100% Recyclable

2025 RELEASE UNDER E.O. 14176

6

• *Today's Date* is one line.

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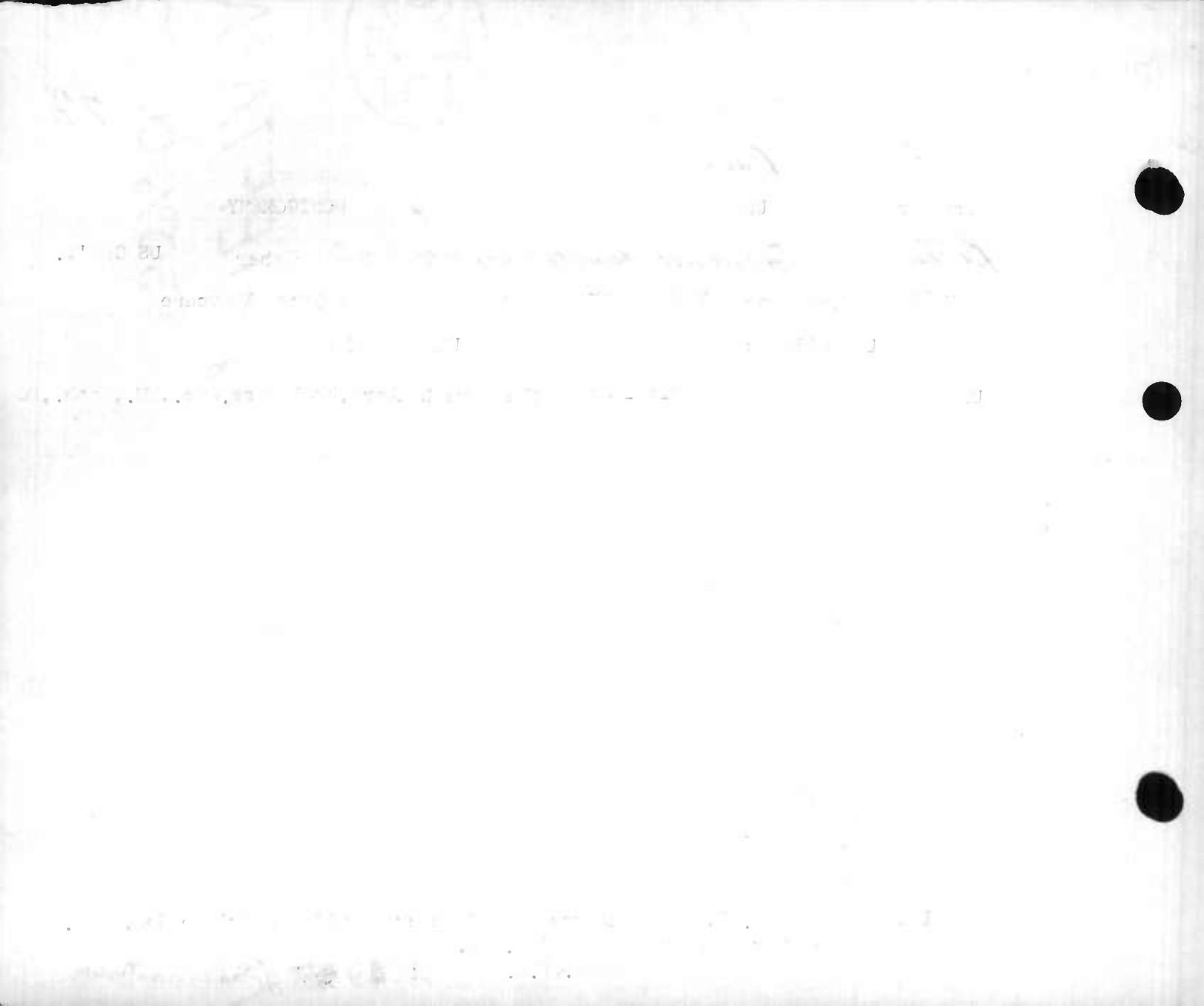
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "X" item 18 shows any injury, or other trauma renoted by the hospital or attending physician.

384125

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 85 35006						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR				
<i>Vincent E</i>					<i>Smith</i>	11 30 85					7 PM					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
<i>M</i>		<i>Cauc</i>		MONTH	DAY	YEAR	79			MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
New York		USA					MONTGOMERY									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
<i>Bethesda</i>		<i>Grosvenor Health Care ctr</i>					<i>Cartographer</i>			US Gov't.						
13a. STATE		13b. COUNTY		14. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
Maryland		Montgomery		Takoma Park			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			7051 Carroll Avenue 20912						
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME Unavailable			ADDRESS #255								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			Theodore Lombard, 4801 Mass. Ave., NW, Wash., DC									
Unknown		098-10-7835												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Pulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Aspiration Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>C.V.A - c cerebral</i>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Heart Block - pacemaker</i>																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
		P.M. 19														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>saw the deceased alive on 11/20/85</i> , to <i>19 80</i> , to <i>11/30/85</i> , that (I) (we) last viewed the body after death.																
22b. SIGNATURE <i>R. DeVol</i> DEGREE																
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>11-30-85</i>											
<i>Vivik C Vaid M.D.</i>		7676 New Hampshire Ave														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION									
BURIAL		Dec. 3, 1985		Resurrection Cemetery			CITY OR TOWN Clinton Prince Geo. Md.									
24. FUNERAL DIRECTOR DeVol Funeral Home		NAME <i>Robert A. DeVol</i>		ADDRESS <i>2222 Wisc. Ave. Wash. D.C.</i>			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>J. L. Devol</i>							
BP _____																
DHMH - 16 50M 4/83 (VRA 15, 4)																



006186

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

35 35301

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>W.H. L.</i>	MIDDLE <i>W.</i>	LAST <i>Smith</i>	2a. DATE OF DEATH MONTH <i>01</i>	MONTH <i>12</i>	DAY <i>19</i>	YEAR <i>85</i>	2b. HOUR <i>8:05 P.M.</i>		
3. SEX <i>Male</i>			4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH <i>01</i>			DAY <i>28</i>	YEAR <i>32</i>	6. AGE (IN YEARS LAST BIRTHDAY) YRS <i>53</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS HOURS <i>0</i>	MIN. <i>0</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York USA</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County MD.</i>			
10. CITY OR TOWN OF DEATH <i>Washington</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>Adventist Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Mech Designer</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>			
13a. STATE <i>MD</i>			13b. COUNTY <i>PG</i>			13c. CITY OR TOWN <i>Glen Dale</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>6109 Seabrook Dr. 20719</i>
14. FATHER'S NAME FIRST <i>Tyler</i>			MIDDLE <i>Smith</i>	LAST	15. MOTHER'S MAIDEN NAME FIRST <i>Earline</i>			MIDDLE <i>Oaks</i>	LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>yes</i>			16b. SOCIAL SECURITY NO. <i>579 36 2908</i>			17. INFORMANT ADDRESS <i>Doris Johnson-sister-6415 97th Ave Seabrook Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIOPULMONARY ARREST</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>45 minutes</i>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____												
DUE TO, OR AS A CONSEQUENCE OF												
DUE TO, OR AS A CONSEQUENCE OF												
DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>DEC 10</i> , 19 <i>85</i> , to <i>DEC 19</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>DEC 19</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Sherri Lazin MD</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>12-19-85</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Sherri Lazin</i>			22e. ADDRESS <i>Kaiser Permanente 8300 Corporate Drive</i>									
23a. BURIAL, CREMATION, REMOVAL SPECIFY <i>Burial</i>			23b. DATE <i>Dec 26 1985</i>			23c. NAME OF CEMETERY OR CREMATORIUM <i>Harmony Memorial Park</i>			23d. LOCATION CITY OR TOWN <i>Landover, Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>John J. Stewart III</i>			24b. ADDRESS <i>Stewart Funeral Home-4001 Benning Road NE.</i>			25a. DATE REC'D. BY REGISTRAR <i>DEC 31 1985</i>			25b. REGISTRAR'S SIGNATURE <i>Julie Davidson-Parker</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please mail to the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

33130

33130

VOIDED DEATH CERTIFICATE NUMBER 85-35308

See: Yvonne Smith, 1/3/86 - Mont. Co.

April, 1986 death drawer



353219

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move cert. to papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 353219				
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
			Emma J			Snyder			12/4/85			1859 M				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
female			white			Feb. 10, 1906			79							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland			U.S.A.						Montgomery County							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Rockville			Shady Grove Ads. Hosp.			homemaker			at home							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 600 Light Street			21230				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Rev. Richard Reichard Rockville, Md.				
Charles Wrightson			Eva D. Butler			no			212-03-9556			9701 Veirs Drive				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (we) attended the deceased from Dec. 4, 1985, to Dec. 19, 1985, that (I) (we) last saw the deceased alive on Dec. 4, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																
22b. SIGNATURE Hysong, M.D.			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 05/1/1985							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas E. O'Connor, M.D.			22e. ADDRESS 17904 Georgia Avenue OLNEY, MARYLAND 20832													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE burial Dec. 9, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cem.			23d. LOCATION CITY OR TOWN Baltimore, Maryland			COUNTY STATE				
24. FUNERAL DIRECTOR NAME The Hysong Co. 1300 N St. N.W. Wash. D.C.			ADDRESS 1300 N St. N.W. Wash. D.C.			25. DATE READ BY DIRECTOR 12/10/85			25b. REGISTRATION SIGNATURE June L. Johnson, R.N.							

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008071

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3 5 3 1 0

1 -  
FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>CATHERINE</i>			<i>ANN</i>	<i>SPRINGER</i>		<i>12</i>	<i>31</i>	<i>85</i>	<i>3:58 A.M.</i>		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 72 HRS	
<i>Female</i>		<i>White</i>		MONTH <i>09</i>	DAY <i>19</i>	YEAR <i>04</i>	<i>81</i>	MONTHS <i>YRS</i>	DAYS <i>0</i>	HOURS <i>0</i>	MIN. <i>0</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i>		MD.			
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hosp</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>SEAMSTRESS</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>COMMERCIAL</i>					
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>SILVER SPRING</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>229 UNIV. BLVD., E., 20901</i>			
14. FATHER'S NAME FIRST <i>UNKNOWN</i>		MIDDLE <i>McDEVITT</i>		LAST		15. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>		ADDRESS <i>3600 EDELMAR TERRACE SILVER SPRING, MD. 20906</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>578-12-0718</i>		17. INFORMANT <i>NEPHEW ROBERT F. SPRINGER</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>					
18. CAUSE OF DEATH (Enter only one cause per line for item 1b, and item 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardiac arrest		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Unknown</i>		DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) this hospital attended the deceased from <i>Jan 18</i> , 19 <i>85</i> , to <i>Dec. 31</i> , 19 <i>85</i> , that (1) (we) last saw the deceased alive on <i>Dec 18</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>Eino Magi, M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>12/31/85</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>EINO MAGI</i>		22e. ADDRESS <i>11120 New Hampshire Av., Silver Spring, Md 20904</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>1/3/86</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>MT. OLIVET CEMETERY</i>		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS, JR.</i>		ADDRESS <i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 6 1986</i>		25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Pendleton</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN. Law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours of death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

retained by the hospital or attending physician.

10-10



364169

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 5 3 1 1

REG. NO.

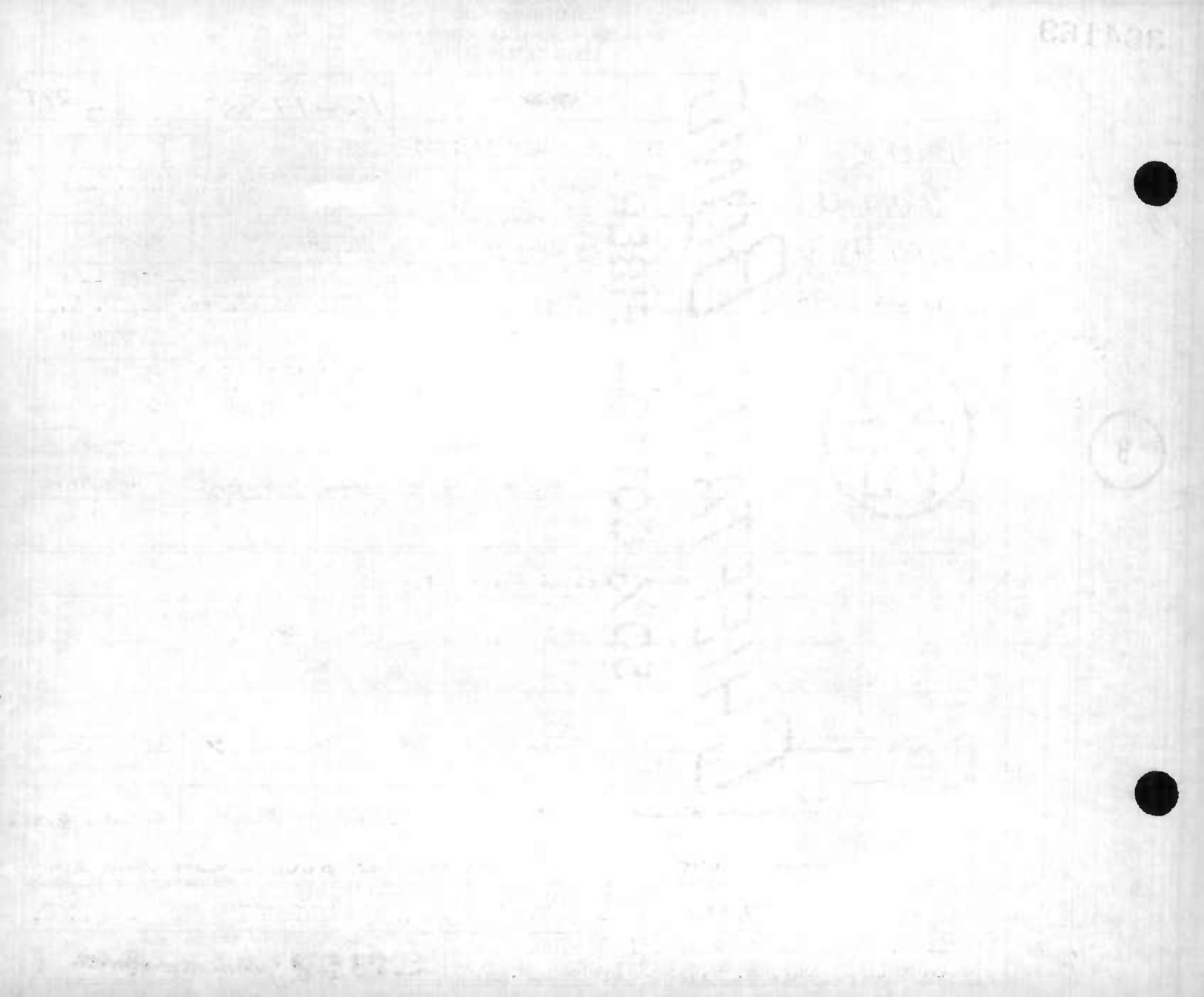
1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>HARRY</b>	MIDDLE <b>STAR</b>	LAST	2a DATE OF DEATH <b>12-19-85</b>	MONTH DAY	YEAR	2b HOUR <b>5:29 P.M.</b>		
3. SEX <b>Male</b>	4 RACE <b>W HITE</b>	5. DATE OF BIRTH <b>FEBRUARY 28, 1903</b>		6. AGE [IN YEARS LAST BIRTHDAY] <b>82</b>	IF UNDER 1 YEAR MONTHS YRS		IF UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Poland</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD.</b>						
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hosp. 3B.</b>			12a USUAL OCCUPATION <b>MERCHANT</b>	12b KIND OF BUSINESS OR INDUSTRY <b>BAKER</b>					
13a STATE <b>D.C.</b>	13b COUNTY <b>none</b>	13c CITY OR TOWN <b>Washington</b>	13d INSIDE CITY LIMITS? <b>YES</b>	13e STREET ADDRESS / ZIP CODE <b>7730 EASTERN AVENUE, N.W. -20012--</b>						
14 Father's NAME <b>DAVID</b>	MIDDLE <b>STAR</b>	15 Mother's Maiden Name <b>FLUMA</b>	MIDDLE	BACHER						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? <b>NO</b>	16b SOCIAL SECURITY NO. <b>111-10-7898</b>	17 INFORMANT <b>WALTER STAR, 7001 LOCH LOMOND DRIVE BETHESDA, MARYLAND</b>	ADDRESS <b>Collectors</b>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b>						
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Peripheral Vascular Disease months										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>Chronic Renal Failure</b>										
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d INJURY OCCURRED <b>NOT WHILE AT WORK</b>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET	CITY OR TOWN	COUNTY	STATE				
22a I certify that (I) <input checked="" type="checkbox"/> hospital attended the deceased from <b>December 13, 1985</b> to <b>December 18, 1985</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>December 18, 1985</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.										
22b SIGNATURE <b>Barry Weiss</b>	DEGREE <b>M.D.</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c DATE SIGNED <b>December 19, 1985</b>							
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Barry Weiss</b>	22e ADDRESS <b>3929 FAIRFIELD DRIVE, WAKATONKA, MD 20906</b>									
23a BURIAL, CREMATION, REMOVAL (5) <b>BURIAL</b>	23b DATE <b>12/20/1985</b>	23c NAME OF FUNERAL HOME OR CEMETERY <b>HEBREW SHOLOM TALEMUD TORAH CONGREGATION CEMETERY</b>		LOCATION <b>WASHINGTON</b>	23d DATE REC'D. BY REGISTRAR <b>DEC 23 1985</b>		23b REGISTRAR'S SIGNATURE <b>Julie Davidson-Bonello</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C.</b>										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician or attending physician, it should be detached from this certificate and completely filled in by the funeral director. Page 3 should be detached from this certificate and removed from paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner's number and name must be added to Part 2.

Carmer



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8535312

352002

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
			John	W.	Starke	12	7	1985	2:15 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Caucasian		Feb. 18, 1902		83		YEARS	MONTHS	DAYS	HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Virginia		United States								Montgomery County MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY					
Bethesda		Suburban Hospital		Engineer		Telephone Co.					
13a STATE		13b COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e STREET ADDRESS / ZIP CODE			
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10201 Grosvenor Place			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						
		John	W.	Starke	Annie						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Yes		577-01-2946		John W. Starke		1 Travilah Terrace Potomac, MD 20854		16 hours			
<p>18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  <b>PART I. DEATH WAS CAUSED BY.</b>          IMMEDIATE CAUSE (a) <u>SEVERE HYPOTENSION</u>          DUE TO, OR AS A CONSEQUENCE OF          (b) <u>GRAM NEGATIVE SEPSIS</u>          DUE TO, OR AS A CONSEQUENCE OF          (c) <u>PERITONITIS</u>  <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I</b>  <u>OSTEOPOROSIS, CONGESTIVE HEART FAILURE, DUODENAL ULCER</u></p>											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED  WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
<p>22a I certify that (I) (this hospital) attended the deceased from <u>11 July</u>, 19<u>80</u>, to <u>7 Dec</u>, 19<u>85</u>, that (I) (we) last saw the deceased alive on <u>7 Dec</u>, 19<u>85</u>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
Eugene P. Libé		MD				<u>7 Dec 85</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		<u>10400 Connecticut Ave</u> <u>Washington Md. 20795</u>							
Eugene P. Libé MD											
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		Dec 13, 1985		Arlington National		Arlington					
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
		Robert A. Pumphrey Funeral Homes									
		7557 Wisconsin Ave. Bethesda, MD 20814		PA		DEC 16 1985					

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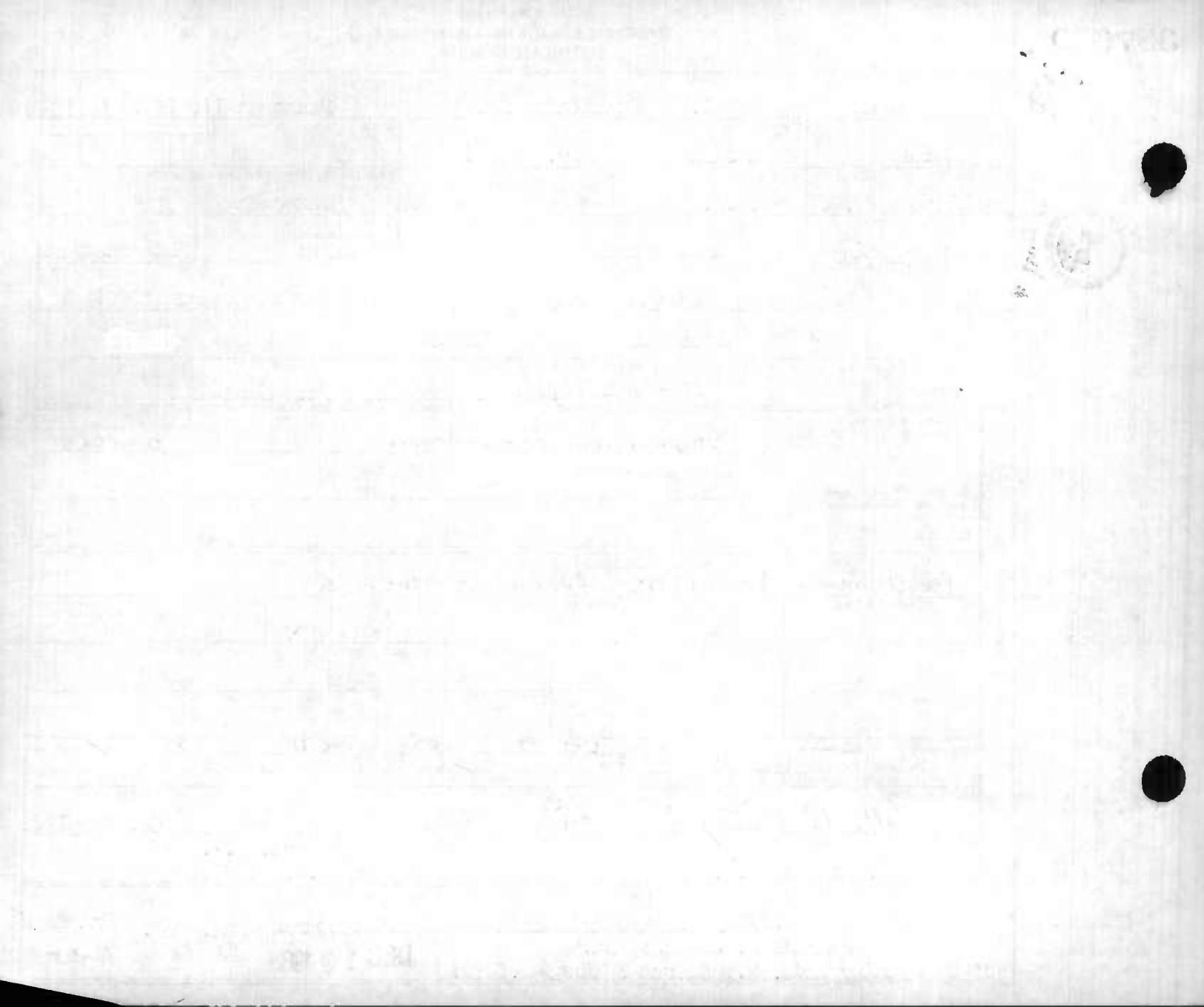
357080

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8535315			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR	
John			L.	Stecklein, Sr.		December 11, 1985						10:15AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Caucasian		Nov. 22, 1900			85			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Washington, D.C.		U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			Montgomery			Auth Brothers			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Silver Spring		Holy Cross Hospital								Butcher			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			
Maryland		Montgomery		Silver Spring			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			9127 Flower Avenue 20901			
14. FATHER'S NAME		MIDDLE		15. MOTHER'S MAIDEN NAME						16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
John		Stecklein		Lottie						6 weeks			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
no				578-05-2254			John L. Stecklein, Jr. Same as 13						
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b1), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Staphylococcal Pneumonia</u>													
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Pseudomonas Tracheitis; Pernicious Anemia</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		P.M.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from Oct 22, 1985, to Dec 11, 1985, that (we) last saw the deceased alive on Dec 11, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (II) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Allen A. Nimetz, M.D.</u>		22c. DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>Dec. 12, 1985</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 5401 Western Ave. N.W. Washington, D.C. 20015											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 12/14/85		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln			23d. LOCATION CITY OR TOWN			COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd. W., Silver Spring, Md. 20901		25a. DATE REC'D. BY REGISTRAR DEC 19 1985								25b. REGISTRAR'S SIGNATURE <u>Susan Larson-Pender</u>			



343068

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 5 3 1 1

REG. NO.

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Harriet</i>			<i>M.</i>	<i>Steingrebe</i>		<i>12/1/85</i>				<i>7:05 P</i>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		8. UNDER 24 HRS	
<i>Female</i>		<i>Caucasian</i>		<i>4</i>	<i>07</i>	<i>94</i>	<i>91</i>	<i>MONTHS</i>	<i> DAYS</i>	<i>HOURS</i>	<i>MIN.</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
<i>New York</i>		<i>U.S.A.</i>				<i>Montgomery</i>					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
<i>Silver Spring</i>		<i>Holy Cross H.S.</i>		<i>Homemaker</i>							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13e. STREET ADDRESS / ZIP CODE	
<i>Maryland</i>		<i>Montgomery</i>		<i>Silver Spring</i>		<i>473 Southampton 20903</i>					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
<i>John Reith</i>						<i>Emma</i>				<i>Reidlen</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		18. ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<i>No</i>		<i>216-18-6608</i>		<i>June M. Kentlein</i>		<i>1020 Heather Ave. Takoma Park, 20912</i>		<i>10 hours</i>			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)										<i>acute gastritis and hemorrhage</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>clotting abnormality</i>										<i>days</i>	
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>12/1/85</i> to <i>12/1/85</i> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <i>12/1/85</i> and that in my <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.											
22b. SIGNATURE <i>Milton J. Reith M.D.</i>											
22c. DEGREE											
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22e. ADDRESS <i>2101 medical Park Dr. Silver Spring Md. 20902</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>											
23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln</i>		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE			
<i>Dec. 4, 1985</i>											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. DECEASED'S SIGNATURE					
<i>Francis J. Collins</i>				<i>DEC 5 1985</i>							
500 University Blvd. W. Silver Spring, Md. 20901											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed in by the attending physician. If filed later than 24 hours after death, page 3 should be detached for use as a burial permit. Then please remove carbon copies. It should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as a burial permit. Then please remove carbon copies. It should be detached for use as a burial permit. Then please remove carbon copies. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the

retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>MARIE B. STEVENSON</i>						<i>10. 14. 85</i>	<i>8</i>	<i>14</i>	<i>85</i>	<i>9.35 AM</i>	
3. SEX			RACE	S. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)						
<i>F female</i>			<i>White Caucasian</i>	<i>09 25 01</i>	<i>84</i>						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	1. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
<i>Washington D.C.</i>			<i>U.S.A.</i>		<i>Baltimore City</i>			<i>Montgomery Co.</i>			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
<i>Rockville</i>			<i>Collingswood Nursing Home</i>			<i>mailroom clerk</i>			<i>PEPCO</i>		
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE					
<i>Maryland</i>			<i>Montgomery</i>	<i>Chevy Chase</i>		<i>4701 Williard Ave. 20814</i>					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
<i>Felix</i>			<i>A.</i>	<i>VanReuth</i>	<i>Victoria</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.	17. INFORMANT	18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
<i>No</i>			<i>577-05-0259</i>	<i>(Son)</i>							
18. CAUSE OF DEATH (Enter only one cause per line for items (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a))			<i>Pneumonia. Severe.</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>12/14/85</i> , 19 <i>85</i> , to <i>12/14/85</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>12/14/85</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>H. D. Oliver</i> DEGREE											
22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. ADDRESS <i>8218 W. Covington Ave. Bethesda</i>			22e. DATE SIGNED <i>12/14/85</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>12/17/85</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National</i>		23d. LOCATION CITY OR TOWN <i>Arlington</i>			COUNTY	STATE <i>Virginia</i>	
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins, Jr.</i>		ADDRESS <i>500 University Blvd. W. Silver Spring, Md. 20901</i>			25a. DATE REC'D. BY REGISTRAR <i>DEC 19 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Johanna L. Anderson-Pender</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified to the State Board of Health, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical

208 CONSTITUTION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1000. PAGE 5 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 MAY BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

35310

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY	6. AGE (IN YEARS LARGE DAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS	
14. FATHER'S NAME FIRST			15. MOTHER'S MAIDEN NAME FIRST										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
NO			207-05-7273			LEGAL REP VIOLET I. TRUMPOWER, EDGEWATER, MD.			3650 BAY DRIVE			STINE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart attack due to old disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>None</i>													
19a. DATE OF OPERATION <i>None</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY) <i>John S. Rogers, M.D., D.P.M.</i>												DATE SIGNED <i>Dec 24/1985</i>	
ACTUAL SIGNATURE <i>John S. Rogers</i>			EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			1919 SENTINEL RD., SILVER SPRING, MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE
CREMATION			12/25/85			METROPOLITAN CREMATORIAL			ALEXANDRIA			VIRGINIA	
24. FUNERAL DIRECTOR NAME			FRANCIS J. COLLINS, JR.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			<i>John Pendleton</i>	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						JAN 02 1986							

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 5 3 5 3 1 7

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Catherine H. Sullivan						Dec. 27, 1985				1:10PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		2d. HOUR	
Female		White		MONTH June DAY 11, 1899 YEAR		86		MONTHS DAYS		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Virginia		USA						Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda		Fernwood Nursing Home		Clerk - Gov't. Printing Office		20843					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	Bethesda				6530 Democracy Blvd.				
Maryland	Mont.	Bethesda									
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
John			Hayes	Cecilia							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. unavailable		17. INFORMANT		ADDRESS		Potomac, Md.			
				Son - James M. Sullivan 10008 Carmelita Dr.							
18. CAUSE OF DEATH (Enter only one cause per line for each cause listed) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						DUE TO, OR AS A CONSEQUENCE OF (b)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate			
						DUE TO, OR AS A CONSEQUENCE OF (c)		7 years.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) <input type="checkbox"/> attended the deceased from now to the deceased died on 19 85		3/30 1985		19 85		to 12/27 1985					
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED					
22c. PHYSICIAN'S NAME (TYPE OR PRINT)				J. Blaine Fitzgerald, M.D.		12/27/85					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION					
Burial		Dec. 30 '85		Cedar Hill Cemetery		Suitland, Maryland					
24. FUNERAL DIRECTOR NAME		DeVol Funeral Home ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
James E. DeVol		Washington, D.C.		JAN 3 1986		Julia Davidson DeVol					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by you, it should be detached for use as the burial/transit permit. Then please attach this certificate to the death report, or if you do not have a death report, attach this certificate to the burial/transit permit. With the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant condition contributing to death, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "Yes" at time of death, or if there is any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3 5 3 5 1 8

345126

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Laura				M.	Talbott		December	3,	1985		5 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)						
Female		Caucasian		Nov. 6, 1888		97 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.		10. CITY OR TOWN OF DEATH					9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		United States		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Rockville					Montgomery County MD.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY					
122 South Van Buren Street		Homemaker					Home					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE ADDRESS BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?					13e. STREET ADDRESS / ZIP CODE	
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					122 South Van Buren Street 20850	
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
		John	T.	Higgins	Laura					Magruder		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT					ADDRESS			
No		220-44-4578		Son					9404 Columbia Blvd. William R. Talbott Silver Spring, MD			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b) and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u>												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>foot ulcer infection</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET					CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 21, 1985</u> to <u> </u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>10/22 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Mary Fang, M.D.</u>		22c. DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
Mary Fang, M.D.		50 West Edmonston Drive, Rockville, MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		CITY OR TOWN		COUNTY	STATE	
Burial		Dec. 6, 1985		Rockville Cemetery		Rockville		Rockville		Maryland		
24. FUNERAL DIRECTOR NAME <u>ROBERT A. PUMPHREY FUNERAL HOMES</u> ADDRESS <u>PA. 300 West Montgomery Ave. Rockville, MD</u>												
DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE <u>DEC 9 1985</u>												

6312.6

364030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial/memorial service. Then please retain copy of page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked as Item 18 (burial only) or other voluntary event, the medical examiner's signature will be omitted on item 21.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3531	
												REG. NO.	
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
Pui Yee Tam									Dec 10 1985			13:45	
3. SEX Female			4. RACE Chinese			5. DATE OF BIRTH MONTH Dec. DAY 15 YEAR 1901			6. AGE IN YEARS LAST BIRTHDAY 83 YRS			IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE COUNTRY China			7b. CITIZEN OF WHAT COUNTRY? China			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery			IF UNDER 24 HRS HOURS MIN.	
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12201 Braxfield Cr. #9			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WORKER			12b. KIND OF BUSINESS OR INDUSTRY Private				
13a. STATE MD			13b. COUNTY Montgomery			13c. CITY OR TOWN Rockville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 12201 Braxfield Cr. #9 / 20852	
FATHER'S NAME FIRST YEE			MIDDLE Chu			LAST Liu			15. MOTHER'S MAIDEN NAME Wong			LAST SHEE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 579-58-1856			17. INFORMANT Chew Mon Hom (Husband)			ADDRESS Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for item 18, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>massive cerebrovascular accident</u> (c) <u>cerebrovascular insufficiency</u>												2 month 2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Pt in coma x 2 month</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER NOTIFY MEDICAL EXAMINER			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-5-1985</u> , to <u>12-10-1985</u> , that (I) (we) last saw the deceased alive on <u>12-5-1985</u> and that in (my) our opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.													
22b. SIGNATURE <u>John S. Gallo Jr. MD</u>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 14/11/85				
22e. ADDRESS 5225 Rockville Rd., Bethesda, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12-11-1985			23c. NAME OF CEMETERY OR CREMATORIAL Lee's Crematory			23d. LOCATION CITY OR TOWN Washington, District of Columbia				
24. FUNERAL DIRECTOR NAME J.Wm.Lee's Sons Co, 300-4th St., NE, Wash., DC 20002			ADDRESS			25a. DATE REC'D. BY REGISTRAR DEC 18 1985			25b. REGISTRAR'S SIGNATURE <u>J. Wm. Lee's Sons Co, 300-4th St., NE, Wash., DC 20002</u>				

RETIRED

3

11414576

Chez Mon Hom(Hauspann) Same as 13

xx

100

Classification 15-11-1982 Rec'd a Classified by  
Massachusetts, District of Columbia  
1. Mr. Tee, a Bone Co, 300-4482, Mr. Mass., DCCOCS

351125

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 3 days after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed completely, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 3 5 0 2 0				
										REG. NO.				
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR
			<i>Mabel L. Tanner</i>						<i>12-5-85</i>					<i>50</i>
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		<i>March 12, 1903</i>			82		YEARS	MONTHS	DAYS	HOURS	MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		M.D.					
Virginia		U.S.A.					<i>Montgomery</i>							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
<i>Bethesda</i>		<i>Suburban Hospital</i>		<i>Housewife</i>			<i>Home</i>							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE						
Maryland		Montgomery		Cabin John				<i>7640 Tomlinson Avenue 20818</i>						
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME		ADDRESS								
<i>George</i>		<i>Bradley</i>		<i>Martha</i>		<i>Motley</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
No		<i>577-05-4404</i>		<i>Ruby E. Cole</i>		<i>Same as items 13a-e</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Congestive heart failure</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								<i>42.</i>						
(b) <i>acute myocardial infarction</i>								<i>41</i>						
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
				<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Howard Goldberg</i>										22c. DATE SIGNED <i>12/4/85</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Howard Goldberg</i>		22e. ADDRESS <i>12012 Viers Mill Rd Whorton MD 20852</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/11/85		23c. NAME OF CEMETERY OR CREMATORIAL Greenwood Cemetery		23d. LOCATION CITY OR TOWN Bedford, Virginia								
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 20852				25a. DATE REC'D. BY REGISTRAR DEC 13 1985		25b. REGISTRAR'S SIGNATURE <i>Jane Carlson Pendleton</i>								



365118

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

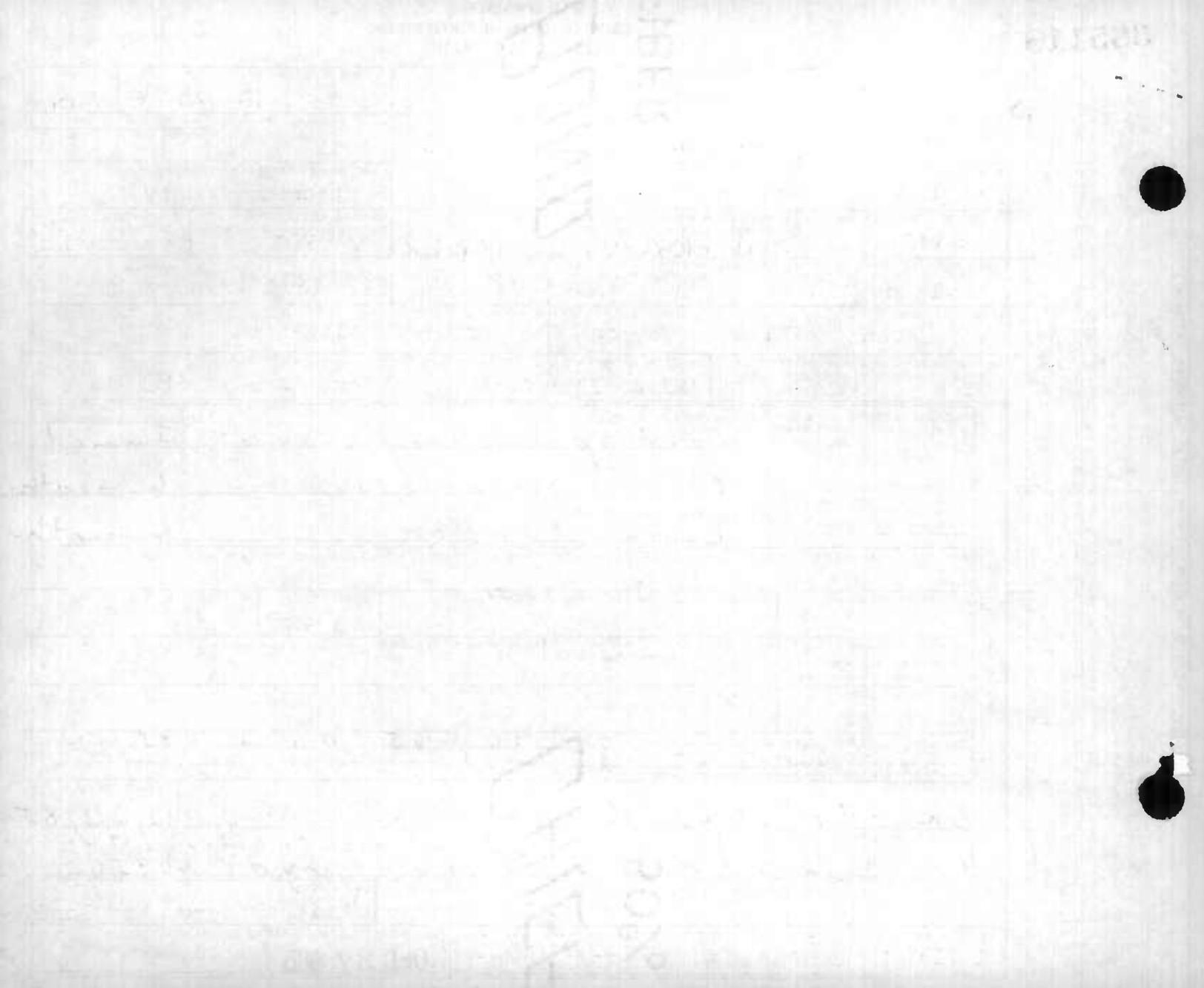
8 5 3 5 3 2 1

1. DECEASED NAME FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
John Henry Taylor, Sr.				12 25 85	8:15 p.m.
3. SEX Male		4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR 59 YRS	
			Sept. 9, 1926	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Surveyor	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	12b. KIND OF BUSINESS OR INDUSTRY County Government	
				20850	
14. FATHER'S NAME FIRST John MIDDLE William LAST Taylor		15. MOTHER'S MAIDEN NAME Annie Elizabeth Day			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II	17. INFORMANT Wife June L. Taylor	ADDRESS Same as item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>I had</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brain metastasis</u> <u>6 months</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Lung cancer</u> <u>6 months</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 27 1985</u> to <u>Dec 25 1985</u> , that (I) (we) last saw the deceased alive on <u>Dec 23 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.					
22b. SIGNATURE DEGREE					
22c. DATE SIGNED <u>12/26/85</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Christopher Sunford		22e. ADDRESS <u>2615 W Montgomery St., Gaithersburg, MD 20850</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 28, 1985	23c. NAME OF CEMETERY OR CREMATORIUM Forest Oak Cemetery	23d. LOCATION CITY OR TOWN Gaithersburg, Maryland	COUNTY STATE
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOME, ADDRESS PA 7557 WISCONSIN AVE. BETHESDA, MARYLAND		25a. DATE REC'D. BY REGISTRAR DEC 27 1985		25b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and delivered to you, it should be detached for use as the burial-transit permit. Then please remove carbon copy. Prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

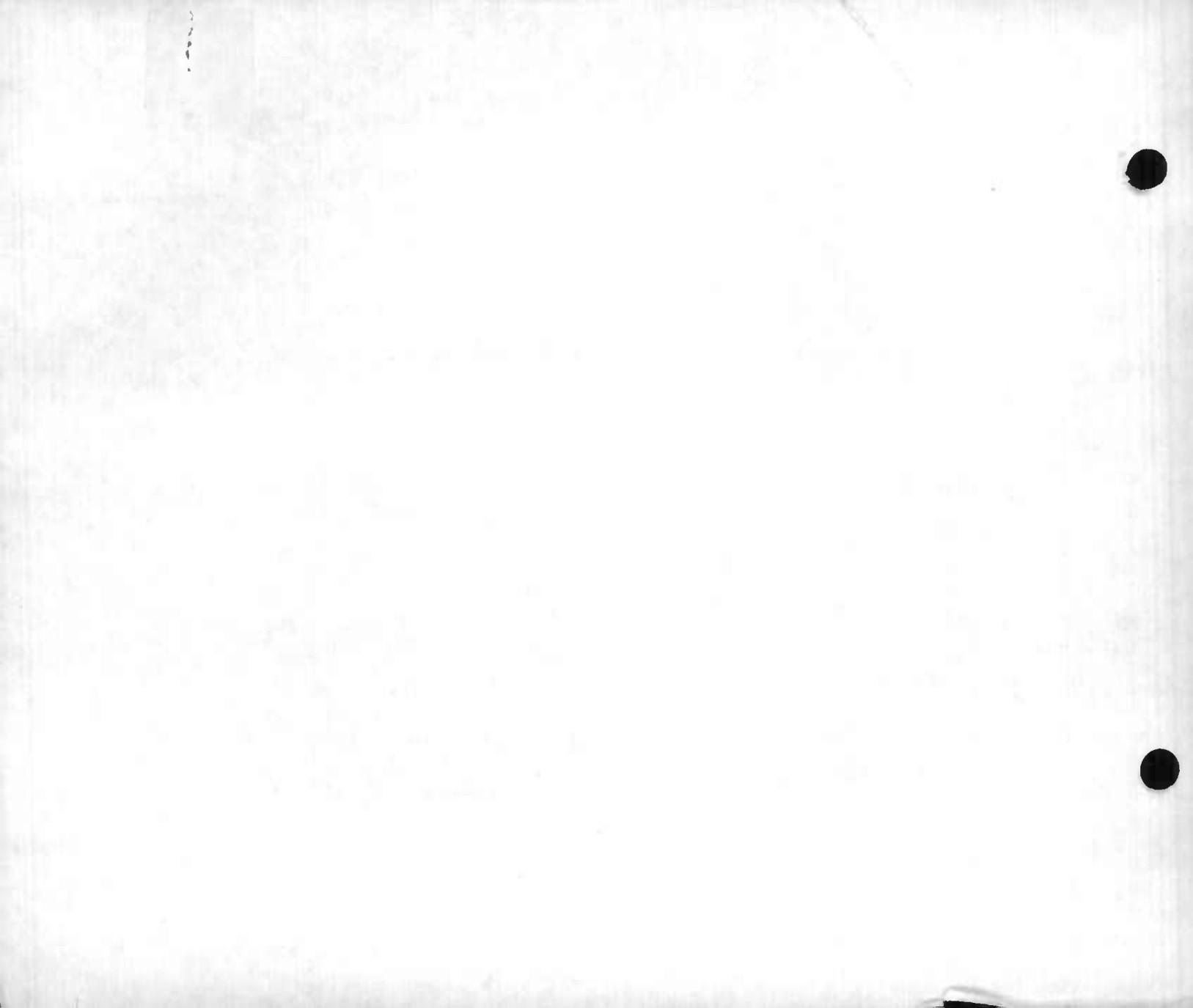
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the



VOIDED DEATH CERTIFICATE NUMBER 85-35322

Lucille S. Taylor - 1/1/86 - Mont. Co.

See: April, 1986 death drawer



007088

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MARY</b>				FIRST <b>M.</b>	MIDDLE <b>TEARPOCK.</b>	LAST	2a. DATE OF DEATH <b>12-24-85</b>	MONTH <b>12</b>	DAY <b>24</b>	YEAR <b>85</b>	2b. HOUR <b>5:35 P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>1</b>		DAY <b>16</b>	YEAR <b>1900</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b>		IF UNDER 1 YEAR <b>YRS.</b>	IF UNDER 24 HRS MONTHS <b>0</b>	DAYS <b>0</b>	HOURS <b>0</b>	MIN. <b>0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>								
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housekeeper</b>						12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4808 Red Fox Road 20852</b>						
14. FATHER'S NAME FIRST <b>Michael</b>		MIDDLE <b></b>	LAST <b>Tearpock</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Anna</b>		MIDDLE <b></b>	LAST <b>Kollar</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>201 26 9615</b>		17. INFORMANT <b>John T. Perkoski</b>		ADDRESS <b>Same as item 13 a-e</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC ADENOID CYCLOPSIS</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b) <b>UNKNOWN PRIMARY</b> (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>12/19/85</b> to <b>12/24/85</b> , that (I) (we) last saw the deceased alive on <b>12/24/85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <b>JLC</b>		22c. DEGREE <b>MD</b>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <b>12/24/85</b>								
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILKLOW C. BRESC</b>		22g. ADDRESS <b>1600 Seven Ave, Takoma Park</b>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/28/85</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Ascension Parrish Cem. Mocanaqua Luzerne Penna.</b>		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE				
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland 20852		25a. DATE REC'D. BY REGISTRAR <b>12/28/85</b>		25b. REGISTRAR'S SIGNATURE <b>TYSON WHEELER</b>										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and stamped by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 21 is checked, the medical examiner will be notified of cause.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE LEFT IN OUR FILES. PAGES 1 AND 2 SHOULD BE KEPT FOR 72 HOURS.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT IN OUR FILES. PAGES 1 AND 2 SHOULD BE KEPT IN OUR FILES. PAGES 1 AND 2 SHOULD BE KEPT IN OUR FILES.

AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3532		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			XX	MONTH	DAY	YEAR	2b. HOUR	
Adam L. Thomas						IF UNDER 1 YR.	IF UNDER 24 HRS.			12-29	19	85	M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS AT DEATH) MONTHS DAYS			MONTHS	DAYS	HOURS	MIN	2c. DATE PRONOUNCED DEAD			2d. HOUR	
Male.	White.	Sept. 26, 1966	YRS.							12-29	19	85	p.m. 12:06	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington D. C.			U. S. A.						Montgomery County, MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Takoma Park			Washington Adventist Hospital			Student.								
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
Md.			Montgomery						1113 Garland Ave. 20812					
14. FATHER'S NAME			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.				ADDRESS		
Thomas R.			Thomas.		Mary P. Pelletier.			578-96-3952				LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) Combined Drug Intoxication (changed PART 1 DEATH WAS CAUSED BY: CARBAMAZEPINE - INTOXICATION - 3/12/86)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No.						Thomas R. Thomas. (13 e )								
19. DATE OF OPERATION													19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 1986			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) SUBJECT INGESTED DRUG			21d. LOCATION 8113 Garland AV CITY OR TOWN TAKOMA PARK COUNTY MD STATE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. TITLE (SPECIFY) Assistant MEDICAL EXAMINER								
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													DATE SIGNED 12-30-85	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn St., Balto., Md. 21201														
23a. BURIAL, CREMATION, REMOVAL METHOD			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL NAME			23d. LOCATION CITY OR TOWN			23e. COUNTY	23f. STATE	
Burial.			Jan. 2, 1986 Gate Of Heaven						Silver Sprg. Montg. Md.					
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Selma Waller			JAN 6 1986			June L. Johnson-Smyth								
(VR A15 ME (5))														

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
<i>James C. Thompson</i>						<i>12-23-1985</i>	<i>12-23</i>		<i>1985</i>	<i>1 PM</i>
3. SEX	M	4. RACE	BLK.	5. DATE OF BIRTH MONTH DAY YEAR	JUNE 26, 1904	6. AGE (IN YEARS LAST BIRTHDAY)	81	YRS.	IF UNDER 1 YEAR	IF UNDER 24 HRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	N.C.	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	Montgomery			MD.
10. CITY OR TOWN OF DEATH	Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	WASHINGTON AD. HOSP.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	LABORER	12b. KIND OF BUSINESS OR INDUSTRY	CONSTR.			
13a. STATE	MD.	13b. COUNTY	P.G.CO.	13c. CITY OR TOWN	CAP. HGTS. MD.	13d. INSIDE CITY LIMITS?	NO	13e. STREET ADDRESS / ZIP CODE	5815-GEO. PALMER HIGHWAY	
14. FATHER'S NAME FIRST	WILLIAM THOMPSON	MIDDLE		LAST	LILLY W. DAVIS	FIRST	MIDDLE	LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)	NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	N/A	17. INFORMANT	EMMA THOMPSON-	ADDRESS	WIFE	5815-GEO. PALMER HIW.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY-			IMMEDIATE CAUSE (a) <i>Pneumonia, Stage D</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) _____						<i>1 yr 3 mos</i>	
			(c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>March 19 84</i> to <i>December 29 85</i> , that (I) (we) last saw the deceased alive on <i>12-23 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Kai-Yin Yew, MD</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>12-24-85</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Kai-Yin Yew, MD</i>	22e. ADDRESS <i>8926 Woodlawn Rd #201 Clinton, MD 20735</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE <i>DEC. 28, 1985</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>HARMONY MEM. PK.</i>	23d. LOCATION CITY OR TOWN <i>LANDOVER, P.G. MD.</i>	23e. DATE REC'D. BY REGISTRAR <i>JAN 6 1986</i>	23f. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pandelle</i>					
24. FUNERAL DIRECTOR NAME <i>H. S. WASHINGTON &amp; SONS</i>	ADDRESS <i>4925 BURROUGHS AVE, N.E.</i>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death or it may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon copies. Pages 1 and 2 (may be retained) may be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

364610

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 35320

1- STATE REGISTRAR		364610																			
1. DECEASED NAME (TYPE OR PRINT)		FIRST JAMES			MIDDLE E			LAST THOMPSON			2a. DATE KNOWN OF ESTI- MATED		MONTH 12 10		DAY 19 85		YEAR 1985		2b. HOUR PM		
3 SEX M		4. RACE N 2		5. DATE OF BIRTH MONTH 12 DAY 23 YEAR 27			6. AGE (IN YEARS LAST BIRTHDAY) 57 yrs.			7. IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. DAYS		HOURS		MIN.					
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY										
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 95 Dawson Ave			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer			12b. KIND OF BUSINESS OR INDUSTRY State Rd. Arm													
13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN Rockville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 95 Dawson Ave 20850												
14. FATHER'S NAME FIRST Emanuel		MIDDLE		LAST Thompson, Sr			15. MOTHER'S MAIDEN NAME FIRST Georgia		MIDDLE		LAST JOHNSON										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-20-2954			17. INFORMANT Georgia Thompson - Rockville, MD			ADDRESS 54 Bickford Lane													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.  (b) ATHEROSCLEROTIC CADAVACULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)  PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). DIABETES MELLITUS																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12 10 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FOUND ON FLOOR																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home			21f. LOCATION STREET 95 Dawson St CITY OR TOWN Rockville Mont COUNTY MD STATE																
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Emanuel C. Mylo</i> M.D. TITLE SPECIFY <i>Set</i> MEDICAL EXAMINER DATE SIGNED <i>12/10/85</i>																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-14-85			23c. NAME OF CEMETERY OR CREMATORIAL Ash Memorial Cem.			23d. LOCATION CITY OR TOWN Sandy Spring, Montg. M.D.		COUNTY		STATE		EXAMINER'S NAME (TYPE OR PRINT) <i>Emanuel C. Mylo</i> ADDRESS 8100 Wisconsin Ave Bethesda MD 20814							
24. FUNERAL DIRECTOR NAME George R. Snowden Rockville, MD 20850		25a. DATE REC'D. BY REGISTRAR DEC 18 1985			25b. REGISTRAR'S SIGNATURE <i>John B. Parker</i>																
DHMH - 17 (VR A15 ME (5))																					

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Vivia Terhune Belbin Thompson							Dec. 3, 1985				11 AM M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		Month Day Year Jan. 25, 1893			92		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA							Montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Chevy Chase		6400 Kennedy Drive		Homemaker			Own Home					
13e. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
MD		Montgomery	Chevy Chase				6400 Kennedy Dr./20815					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE	LAST			
		Frederick	William	Belbin	Genevieve			Duida	Terhune			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS					
No		---		578-07-6219			Robert F. Rickey, Same address as #13.					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, b, and c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cordae arrest						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —				
		due to, or as a consequence of (b) arteriosclerotic heart disease						4 years				
		(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4-11-1985 to 12-3-1985, that (I) (we) last saw the deceased alive on 12-2-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Robert V. Choisser		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/3/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 5530 WI Ave. Chevy Chase, MD 20815										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 12/6/85		23c. NAME OF CEMETERY OR CREMATORIAL St. John's Cemetery			23d. LOCATION Ellicott City, MD					
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE J. E. 12/6/85										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be used as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked  show any injury, or other traumatic event, the medical examiner must be notified.



347080

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 35323

1 - FOR  
STATE  
REGISTRAR

REG. NO.

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d DATE OF DEATH	MONTH	DAY	YEAR	2d HOUR	
<i>Edward Thornton, Sr.</i>			<i>E</i>	<i>G</i>	<i>Thornton, Sr.</i>	<i>12-4-85</i>				<i>2:15 A.M.</i>	
3. SEX	4. RACE	5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	IF UNDER 14 HRS			
<i>M</i>	<i>B</i>	MONTH <i>12</i> DAY <i>14</i> YEAR <i>05</i>				<i>79</i>	YRS	MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.			
VIRGINIA	USA				<i>MONTGOMERY</i>						
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
SILVER SPRING	<i>HOLY CROSS</i>					<i>RETIRED</i>			<i>Barber</i>		
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?			13e STREET ADDRESS / ZIP CODE					
MD	MONTGOMERY	SILVER SPRING	YES <input type="checkbox"/>	NO <input type="checkbox"/>		8715 FIRST AVE					
14 FATHER'S NAME	FIRST	MIDDLE	LAST	14f MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
<i>Benjamin F. Thornton, II</i>				<i>Ruby Lee George</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)		16b SOCIAL SECURITY NO.	17 INFORMANT			ADDRESS				
yes	<i>WWII</i>		<i>578-10-0815</i>	<i>Benj.F. Thornton III</i>			<i>1617 Minn. Ave., S.E. Washington, D.C.</i>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>RESPIRATORY FAILURE</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>MYOCARDIAL INFARCTION</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>RIGHT LUNG PNEUMONIA</i>											
19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>11/29 1985</i> to <i>12/3 1985</i> , that (I) (we) last saw the deceased alive on <i>12/3 1985</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death.											22c. DATE SIGNED
22b. SIGNATURE <i>Daniel J. Woronow MD</i>											<i>12/4/85</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DANIEL J. WORONOW/MD</i>											22e. DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22f. ADDRESS <i>8830 CAMERON ST #304 SILVER SPRING, MD</i>											
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY	23f. STATE		
Burial	<i>12/9/85</i>	Ft. Lincoln Cem.			Brentwood						
24 FUNERAL DIRECTOR	ADDRESS <i>The McGuire Funeral Service, Inc.</i>					25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
						<i>7400 Ga. Ave., NW Washington, D.C.</i>			<i>DEC 9 1985 Julia Davidson Pendleton</i>		

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• 79 •  
Gifford  
Montgomery

spend your  
= 77 hours  
... 3.2 days

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Montgomery • Gifford

on Friday, December 10, 1960, at 10:30 a.m., in the office of the  
Montgomery County Sheriff's Office, in the City of Gifford, Illinois.

353210

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 35329

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
<i>Catherine SLATTERY Thysen</i>						12	6	1985	1:00 PM	
3. SEX		4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
F		C	1	06	1899	86				
7. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i>		
WASH. D.C.		U.S.A.						MD.		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda Suburban Hospital		EXECUTIVE ASST.			U.S. GOVT.					
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) IN STATE D.C. COUNTY		13c. CITY OR TOWN Washington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 5425 Western Ave NW		
14. FATHER'S NAME JOHN J. SLATTERY		15. MOTHER'S MAIDEN NAME MARY E. FRY.								
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 275-05-9814			17. INFORMANT (NEPHEW) PAUL CAIN.			1921 Coradoch St. Silver Spring MD		

18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c:  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*respiratory failure*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

3 wk

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause (b)DUE TO, OR AS A CONSEQUENCE OF  
(b) *septicemia*DUE TO, OR AS A CONSEQUENCE OF  
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

*Malnutrition, Cholecystitis, Cholelithiasis*

19a. DATE OF OPERATION 11-11-85	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>cholecystitis</i>	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) this hospital attended the deceased from 11-6, 1985, to 12-6, 1985, that (I/we) lost saw the deceased alive on 12-6, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) did (did not) view the body after death.					
22b. SIGNATURE <i>James Brodsky</i>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 12-7-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James Brodsky MD</i>	22e. ADDRESS 4701 Willard Ave Chevy Chase MD				
23a. BURIAL, CREMATION, REMOVAL <i>Burini</i>	23b. DATE DEC 10 '85	23c. NAME OF CEMETERY OR CREMATORIAL MT. OLIVET CEM	23d. LOCATION CITY OR TOWN WASHINGTON, D.C.	STATE	
24. FUNERAL DIRECTOR NAME <i>John F. Debel</i> ADDRESS <i>DEVOL FUNERAL HOME</i>	25a. DATE REC'D. BY REGISTRAR DEC 13 1985	25b. REGISTRAR'S SIGNATURE <i>John F. Debel</i>			

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OPTIONAL FORM  
MAY 1962 EDITION  
GSA GEN. REG. NO. 27

100-106-0106

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the physician be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return certificate to physician. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.							
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
MARGARET Helen Tinney						July	13	1906	79	YRS		12	4	85	755 p-m				
3. SEX			4. RACE	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
Female			White	U.S.A.						Montgomery									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Canada			Gaithersburg			19437 Brassie Place			Accountant			Plumbing & Real Estate							
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS											
Md.			Montgomery	Gaithersburg				19437 Brassie Place (20879)											
14. FATHER'S NAME			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
FIRST Arthur			-	Dalmager	FIRST Jessie			211-10-0919A			Willis S. Tinney Gaithersburg, Md. 20879			19437 Brassie Place,					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
No												Cardio respiratory arrest				9 mo.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			(b) Lymphatic Malignancy			DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF			(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE					
22a. I certify that (I) <input type="checkbox"/> attended the deceased from April 17, 19 79, to Dec 4, 19 85, that (I) <input type="checkbox"/> lost saw the deceased alive on Nov. 19 85, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did not) view the body after death.																			
22b. SIGNATURE Carol Bender			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/4/85										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carol L. Bender, M.D.			22e. ADDRESS 11510 Old Georgetown Rd. Rockville, md																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12/6/85			23c. NAME OF CEMETERY OR CREMATORIAL Lee's Crematory			23d. LOCATION CITY OR TOWN Washington, D.C.			COUNTY		STATE					
24. FUNERAL DIRECTOR NAME Gartner Sandison F.H. Gaithersburg, Md. 20877															25. REGISTRAR'S SIGNATURE DEC 10 1987				



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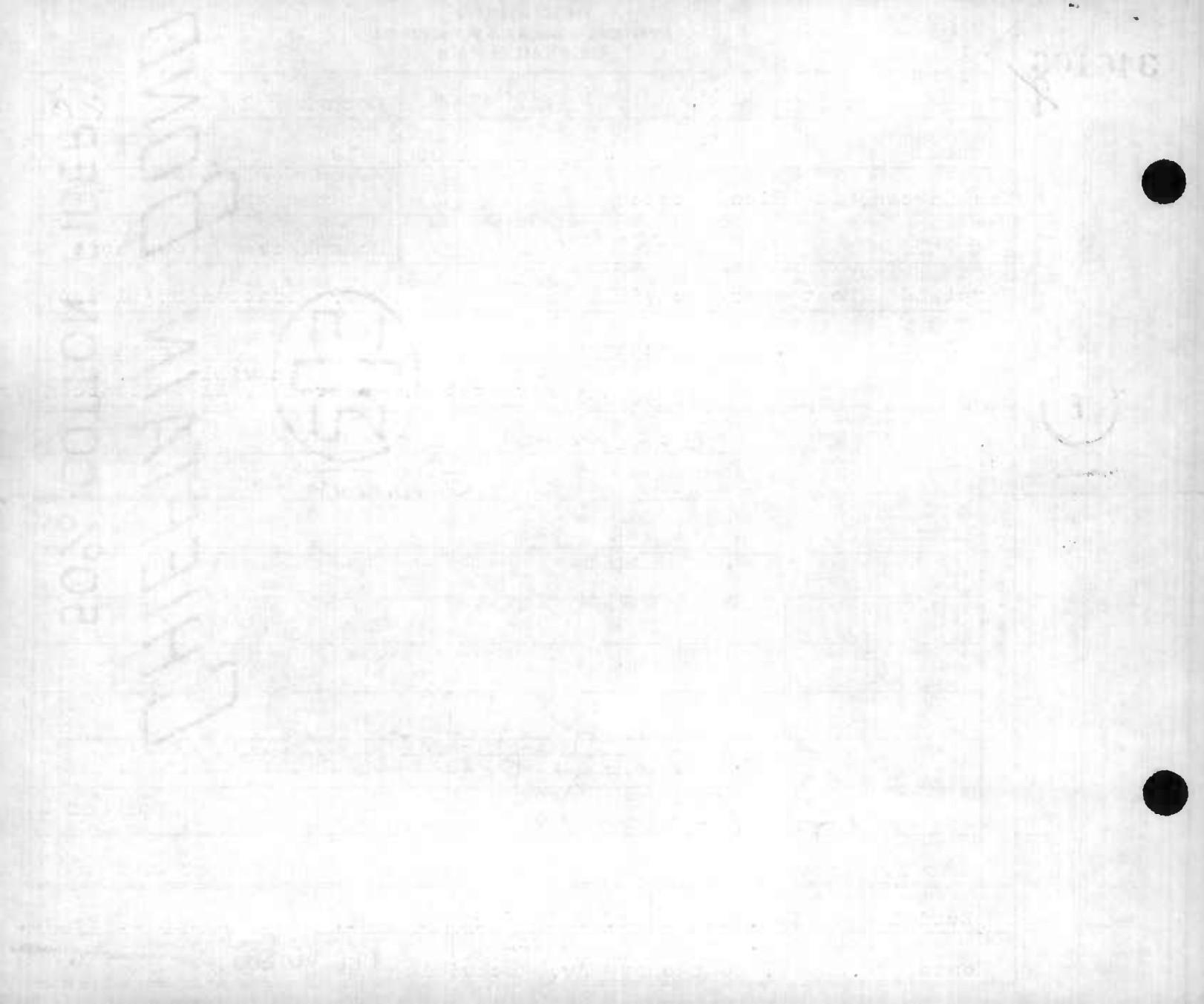
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove from this certificate. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 85353531	
1 - STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Margaret M. Titus						December 2, 1985			8 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS	
Female		Caucasian		July 17, 1906			79 YRS			IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Washington, DC		United States					Montgomery County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL RESIDENCE (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Rockville		1409 Stratton Drive		Homemaker			own home				
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1409 Stratton Dr/ 20854	
14. FATHER'S NAME FIRST: James		MIDDLE: H.		LAST: Mackey			15. MOTHER'S MAIDEN NAME FIRST: Bessie			MIDDLE: Harmon	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS Rockville, Md. 20854			APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH	
no		216 46 3915		Margaret T. Underhill, 2196 Stratton Dr							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA 7 LUNGS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c) <i>&amp; Metastases</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec. 2, 1985, to Dec. 2, 1985, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Leo I. Donovan, M.D.</i>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED December 3, 1985			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
Leo I. Donovan, M.D.					8218 Wisconsin Avenue, Bethesda, MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			STATE	
Burial		Dec. 4, 1985		Mt. Holly Cemetery			Mt. Holly Springs			Penn.	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, PA.		ADDRESS 300 W. Montgomery Av., Rockville		MD			25a. DATE REC'D. BY REGISTRAR DEC 10 1985			25b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>	
VRA 15, 4											

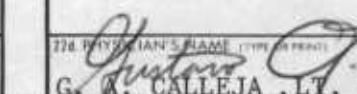


364002

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 3 3 5 0 3 4

1. DECEASED NAME (TYPE OR PRINT) <b>RICHARD ERNEST TOWNSEND</b>				2a. DATE OF DEATH <b>DECEMBER 15 1985</b>				2b. HOUR <b>9:45 a.m.</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>MONTH DAY YEAR OCTOBER 16 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b>		7. IF UNDER 1 YEAR MONTHS DAYS YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>					
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MUSICIAN</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>TEMPLE HILLS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4005 ROCKY MOUNT DRIVE 20748</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE NMN TOWNSEND</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARION NMN IBBOTSON</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1933-1957</b>		17. INFORMANT <b>MARIE A. TOWNSEND, 4005 ROCKY MOUNT DRIVE, TEMPLE HILLS, MD 20748</b>		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>											
DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION</b>											
DUE TO, OR AS A CONSEQUENCE OF (c) <b>DIABETES MELLITIS</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>DECEMBER 11, 1985</b> to <b>DECEMBER 15, 1985</b> , that (I) (we) last saw the deceased alive on <b>DECEMBER 15, 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 					22c. DEGREE <b>MD</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. CALLEJA, LT. MC, USNR</b>					22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <b>Burial 12-19-85</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Arlington, Virginia</b>				
24. FUNERAL DIRECTOR NAME <b>Arlington Funeral Home</b>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>DEC 18 1985</b>							
ADDRESS <b>Arlington, Virginia</b>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the Funeral Director, then please remove these papers. Pages 1 and 2 should be retained for use on the Death and Mental Hygiene prior to burial, or until the State Dept. of Health and Mental Hygiene certifies that the medical examiner has certified at death.

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return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be submitted to you on the burial/burial permit. Then please remove carbon copies. Pages 1 and 2 should be submitted with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

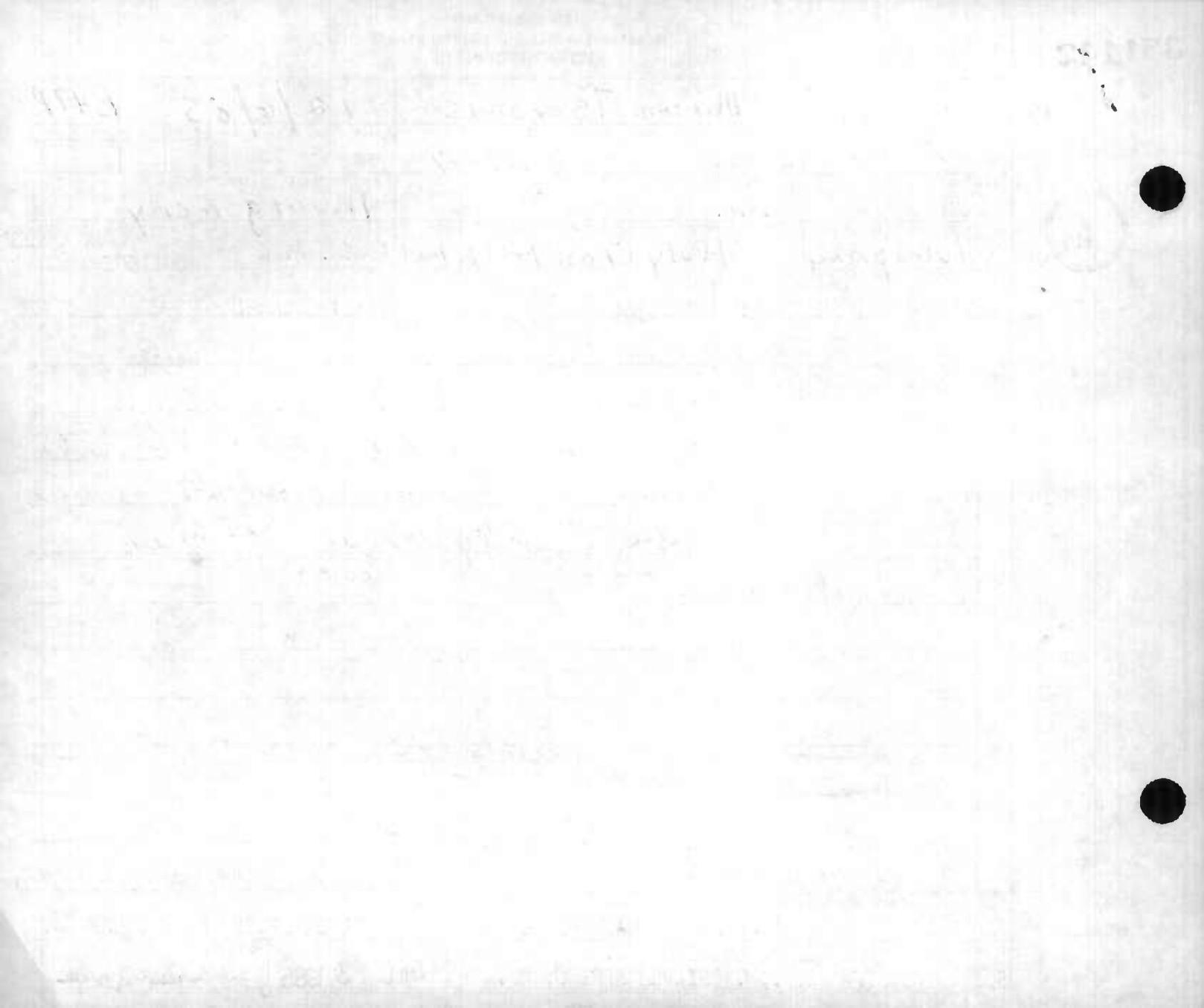
351142

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 3 5 3 3 3

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
VERNA				Miriam Tseronis			12/6/85			1049P			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE		CAUCASIAN		MONTH DAY YEAR			54		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		Montgomery				
MICHIGAN		U.S.A.		1-28-31			10a. CITY OR TOWN OF DEATH		10b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
Silver Spring		Holy Cross Hospital					ADMIN. AIDE		10c. KIND OF BUSINESS OR INDUSTRY MONTGOMERY COLLEGE				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		13f. ADDRESS		
MARYLAND		MONTGOMERY		WHEATON			YES <input type="checkbox"/> NO <input type="checkbox"/>		11601 BUCKNELL DRIVE		20902		
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
Alex				Kampman			Matilda				Wesala		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT HUSBAND		ADDRESS				
NO				384-28-9030			CONSTANTINE H. TSERONIS		SAME AS 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal and cardiac failure</i>												APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Diabetic glomerclerosis; arteriolosclerosis</i> 3-4 years													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Diabetes mellitus; cerebral vascular disease</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL CONDITION GIVEN IN PART 1(a) <i>Hypertension</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>December 6, 1985</i> , to <i>12/7/85</i> , that (I) (we) lost saw the deceased alive on <i>12/6/85</i> , and that in (my) ( <input type="checkbox"/> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <input type="checkbox"/> ) did not view the body after death.												22c. DATE SIGNED <i>12/7/85</i>	
27a. SIGNATURE <i>Reiji Arai</i>		27b. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
27c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jason Geiger, MD</i>		27d. ADDRESS <i>2830 CAMERON ST. SILVER SPRING MD 20910</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>12/10/85</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>GATE OF HEAVEN</i>			23d. LOCATION CITY OR TOWN <i>SILVER SPRING MONTGOMERY MD.</i>						
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS, JR.</i>		24b. ADDRESS <i>500 UNIVERSITY BLVD., W. SILVER SPRING, MD.</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 13 1985</i>			25b. REGISTRAR'S SIGNATURE <i>Jeanne Landon Pendleton</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use on the burial permit. Then please remove carbon papers. Page 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

002113

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 35334

1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR					REG. NO.			
2. DECEASED NAME FIRST MIDDLE LAST			DECEMBER 26, 1985					2b. HOUR			
BURL ARTHUR TULLER								9:05 PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR			
APRIL 20, 1926				59				MONTHS DAYS			
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY IOWA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY		IF UNDER 24 HRS			
10. CITY OR TOWN OF DEATH POTOMAC		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12841 HUNTSMAN WAY		12a. USUAL OCCUPATION CONSULTANT		12b. KIND OF BUSINESS OR INDUSTRY COMPUTERS		MD.			
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN POTOMAC		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 12841 HUNTSMAN WAY 20854		
14. FATHER'S NAME FIRST MIDDLE LAST ARTHUR LEROY TULLER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERTRUDE EVONA JACKSON								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) YES WWII			16b. SOCIAL SECURITY NO. 564-20-9453		17. INFORMANT BURNICE L. TULLER, WIFE, SAME AS ITEM #13		ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma,</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>probably lung Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22b. I certify that (I) (the hospital) attended the deceased from <u>10/28</u> , 19 <u>85</u> , to <u>12/26</u> , 19 <u>85</u> , that (I) <u>saw</u> the deceased alive on <u>12/17</u> , 19 <u>85</u> , and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> (did not) view the body after death.											
22c. SIGNATURE <u>Newman</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>12/27/85</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN J. NEWMAN, M.D.		22e. ADDRESS 19261 MONTGOMERY VILLAGE AVE., GAITHERSBURG, MD									
23a. BURIAL, CREMATION, REMOVAL <u>CREMATION</u>		23b. DATE <u>12/27/85</u>		23c. NAME OF CEMETERY OR CREMATORIAL METROPOLITAN CREMATORIAL		23d. LOCATION CITY OR TOWN ALEXANDRIA, COUNTY VIRGINIA STATE					
24. FUNERAL DIRECTOR RICHARD RAPP, INC. 1804 T ST., N.W., WASHINGTON, D.C. 20009		25a. DATE REC'D. BY REGISTRAR <u>DEC 30 1985</u>		25b. REGISTRAR'S SIGNATURE <u>Judie Davidson</u>							

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361054

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 5 3 3 5

REG. NO.

1 -  
FOR  
STATE  
REGISTRAR

1. DECEASED NAME      FIRST      MIDDLE      LAST				2d. DATE OF DEATH      MONTH      DAY      YEAR				2b. HOUR	
JOHN      GOODE      URQUHART				DECEMBER 21 1985				0920 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
MALE		CAUCASIAN		MONTH      DAY      YEAR		79		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MONTHS      DAYS	
WASHINGTON, D.C.		UNITED STATES				MONTGOMERY		HOURS      MIN.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		MD.	
BETHESDA		NAVAL HOSPITAL		RETired Officer		U. S. NAVY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
MARYLAND		MONTGOMERY		CHEVY CHASE				117 HESKETH ST. 20815	
14. FATHER'S NAME		FIRST      MIDDLE      LAST		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT	
JOHN		GOODE		URQUHART		MARY		ADDRESS	
YES		1928 - 1954		578-50-0549		MARY TYLER HEINER URQUHART 117 HESKETH ST.		CHEVY CHASE, MD 20815	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA									
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) MULTIPLE MYELOMA									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY      STATE	
22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 22, 1985, to DECEMBER 21, 1985, that (I) (we) last saw the deceased alive on DECEMBER 21, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED 12/22/85			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS		NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814					
J. M. GUINEE, LT, MC, USNR									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY	
Burial		12/24/1985		Arlington National Cemetery		Arlington		Virginia	
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisconsin Ave., N.W., Wash., D.C.					25a. DATE REC'D. BY REGISTRAR DEC 24 1985				
					25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-trust permit. Then please leave carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment. IMP 1411. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Retained by the hospital or attending physician.

IMP 1411. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

book 20

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x

which is not difficult via the Lax-Wendroff scheme. This  
is done in the next section.

360101

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8535350

REG. NO.

1 -  
FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
FRANK ARTHUR UTTRIDGE							DECEMBER 17 1985			6:34 a.m.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
MALE		CAUCASIAN		MARCH 27 1918			67			MONTHS	DAYS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS.			
NEW YORK		UNITED STATES					MONTGOMERY			MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
BETHESDA		NAVAL HOSPITAL		13. STREET ADDRESS / ZIP CODE 809 STEWART STREET			14. FATHER'S NAME FIRST MIDDLE LAST			SECURITY			
FLORIDA		SARASOTA		13a. STATE 13b. COUNTY 13c. CITY OR TOWN ENGLEWOOD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA PAULOS			13e. STREET ADDRESS / ZIP CODE 809 STEWART STREET			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) YES 1939-1946		17. INFORMANT IRENE UTTRIDGE, 809 STEWART STREET, ENGLEWOOD,			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EXTENSIVE SMALL CELL LUNG CANCER			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. MEDICAL CERTIFICATION		DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  (b)  DUE TO, OR AS A CONSEQUENCE OF  (c)											
		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 10, 1985, to DECEMBER 17, 1985, that (I) (we) last saw the deceased alive on DECEMBER 17, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>M. Pierdenock</i>		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 17 Dec 85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. PIERDENOCK, LCDR, MC, USNR		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE DEC. 18, 1985		23c. NAME OF CEMETERY OR CREMATORIAL CHAMBERS CREMATORY			23d. LOCATION CITY OR TOWN RIVERDALE, PG. CO. MARYLAND		25a. DATE REC'D. BY REGISTRAR DEC 23 1985		25b. REGISTRAR'S SIGNATURE <i>Julia Pierdenock</i>		
24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME		ADDRESS SILVER SPRING, MD.											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH 16 60M 7/84 (VRA 15, 4)

171035



007120

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

35331

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician (and carried every time it is handled) by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper pages 1 and 2 should a final washing/24 hrs after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

1. DECEASED NAME <i>Rose S.</i>		FIRST ROSE MIDDLE S.	LAST VAN NEWKIRK	2a. DATE OF DEATH <i>December 30, 1985</i>	MONTH DECEMBER	DAY 30	YEAR 1985	2b. HOUR 5:10 P.M.	
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH OCTOBER DAY 25, 1908 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 77	IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS HOURS 0 MIN. 0		
7a. BIRTHPLACE COUNTRY <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i>		12a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>		12c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13. STREET ADDRESS / ZIP CODE <b>6700 BELCREST ROAD 20782</b>			
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>PRINCE GEORGES</b>	13c. CITY OR TOWN <b>HYATTSVILLE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. ADDRESS					
14. FATHER'S NAME FIRST LOUIS	MIDDLE	LAST STANTON	15. MOTHER'S MAIDEN NAME FIRST CLARA	MIDDLE	LAST FRESH				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO. <b>214-07-2297</b>	17. INFORMANT <b>BLANCHE GUNTER, SISTER, SAME AS ITEM #13</b>	18. CAUSE OF DEATH Enter only one cause per line for 10, (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY FAILURE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 MIN</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>SEPTICEMIA</b>		DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEPTICEMIA</b>		3 DAYS					
		DUE TO, OR AS A CONSEQUENCE OF (c) <b>DIVERTICULITIS OF COLON</b>		5 DAYS					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>CHRONIC LYMPHATIC LEUKEMIA TREATED WITH STEROIDS</b>									
19a. DATE OF OPERATION <b>12/29/85</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>DIVERTICULITIS</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) <input type="checkbox"/> attended the deceased from <b>12/28, 1985</b> to <b>12/30, 1985</b> , that (I) <input type="checkbox"/> saw the deceased alive on <b>12/30, 1985</b> and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.									
22b. SIGNATURE <i>Harold S. Tidler M.D.</i>		DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>12/31/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HAROLD S. TIDLER</b>		22e. ADDRESS <b>9801 GEORGIA AVE., SILVER SPRING, MD. 20702</b>							
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>CREMATION</b>	23b. DATE <b>1/1/86</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>METROPOLITAN CREMATORIAL</b>	23d. LOCATION CITY <b>ALEXANDRIA</b> COUNTY <b>VA</b> STATE <b>VA</b>						
24. FUNERAL DIRECTOR <b>RICHARD RAPP, INC.</b> <b>1804 T ST., N.W., WASHINGTON, D.C. 20009</b>	25a. DATE REC'D. BY REGISTRAR <b>JAN 3 1986</b>		25b. REGISTRAR'S SIGNATURE <i>J. Rappendall</i>						



006157

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 5 3 5 3 3 8

REG. NO.

1 - STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>MARY</i>	MIDDLE <i>-</i>	LAST <i>VOGES</i>	2a. DATE OF DEATH MONTH <i>8</i>	MONTH <i>12</i>	DAY <i>22</i>	YEAR <i>85</i>	2b. HOUR <i>2:55 P.M.</i>		
3. SEX <i>F</i>			4. RACE <i>W</i>	5. DATE OF BIRTH MONTH <i>8</i>			DAY <i>18</i>	YEAR <i>1893</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>92</i> YRS.	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i>	MIN. <i>0</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>ENGLAND</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i>			
10. CITY OR TOWN OF DEATH <i>BETHESDA</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>GRISWELL HOSPITAL</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>			
13a. STATE <i>MD</i>			13b. COUNTY <i>MONTGOMERY</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS, ZIP CODE <i>70401 GRISWELL RACE 20732</i>			
14. FATHER'S NAME FIRST <i>David</i>			MIDDLE <i>-</i>	LAST <i>Townend</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Mary</i>			MIDDLE <i>-</i>	LAST <i>Haig</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>115-20-854</i>			17. INFORMANT ADDRESS <i>FREDA YANCE-SAWYER (Daughter) SAWYER</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>9.1.1985</i> to <i>12.22.1985</i> , that (I) (we) last saw the deceased alive on <i>12-20 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>H. Bahar</i>			22c. DEGREE			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			DATE SIGNED <i>12-22-85</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HADI BAHAR</i>			22e. ADDRESS <i>8218 Wisconsin Ave. Bethesda</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>			23b. DATE <i>Dec. 23, 1985</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Lee's Crematory</i>			23d. LOCATION CITY OR TOWN <i>Washington, District of Columbia</i>			
24. FUNERAL DIRECTOR NAME <i>J.Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002</i>			25a. DATE REC'D. BY REGISTRAR <i>DEC 30 1985</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson Pendleton</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that no death certificate be executed within 24 hours of death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from this certificate and placed in the burial permit. Then place remains in casket or urn. If remains are to be cremated, or memorialized, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or memorialization, the medical examiner must be notified at once.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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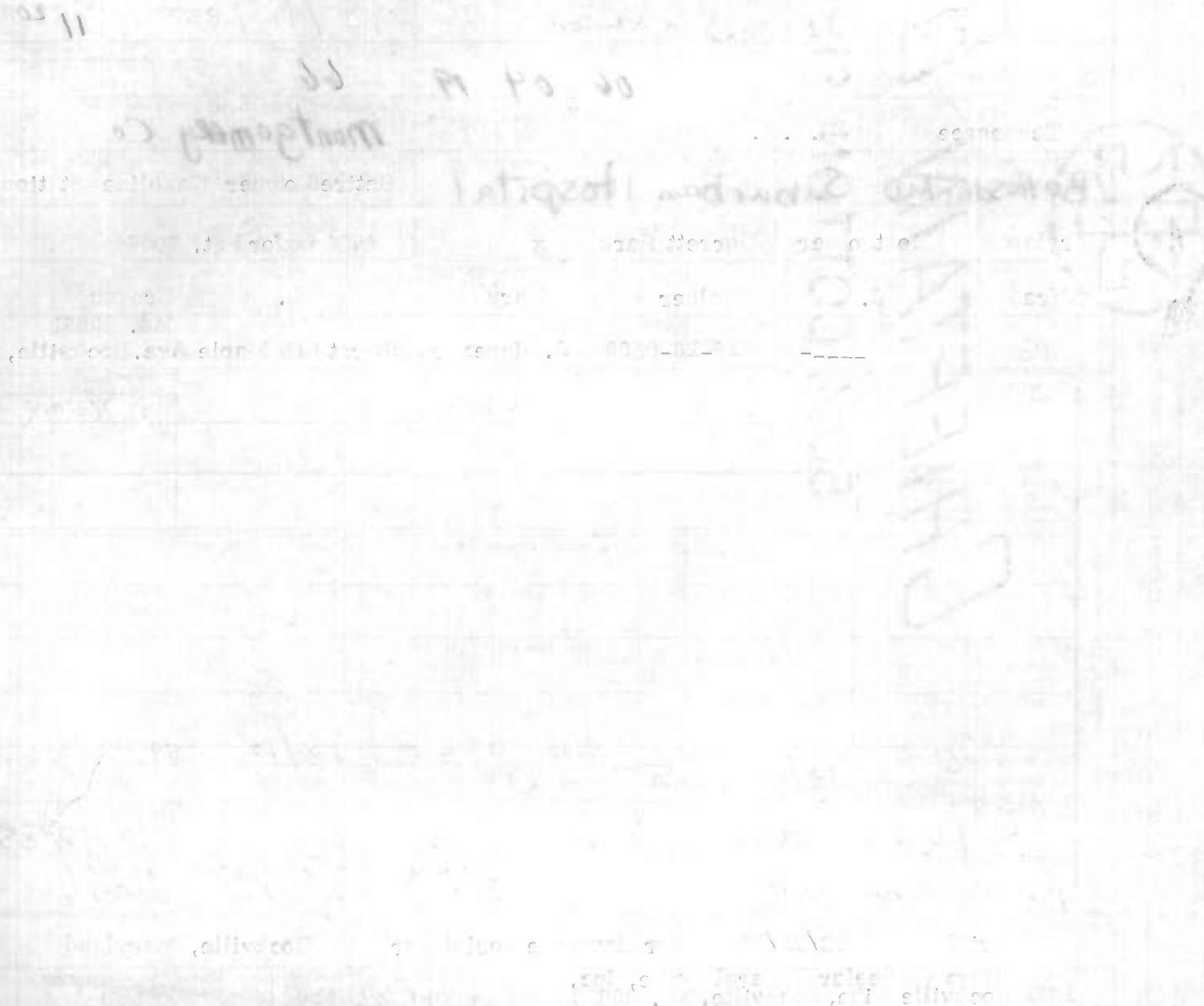
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3535337							
												REG. NO.							
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b. HOUR							
			<b>JAMES EDWARD WALKER</b>						12 17 85			11 20a.m.							
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.							
Male			Cau			06 04 19			66			YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co			10. CITY OR TOWN OF DEATH Bethesda, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (IF OF WORK FOR MOST OF WORKING LIFE) Retired owner		12b. KIND OF BUSINESS OR INDUSTRY Gasoline Station	
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Garrett Park			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4700 Oxford St. 20766							
14. FATHER'S NAME FIRST Alfred			MIDDLE J.			LAST Walker			15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE L.		LAST Brogan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. No			17. INFORMANT J. Diane Broadhurst			ADDRESS Md. 20851			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LUNG CANCER APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YR							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)			DUE TO, OR AS A CONSEQUENCE OF (c)			DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE						
22a. I certify that (I) this hospital attended the deceased from 12/16/85 to 12/17/85, that (I) we last saw the deceased alive on 12/16/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) we did not view the body after death.																			
22b. SIGNATURE Ralph Nelson			DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/17/85										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RALPH COAN M.D.			22e. ADDRESS 4400 EAST WEST ST. MD. 20814																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/21/85			23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Memorial Park			23d. LOCATION CITY OR TOWN Rockville, Maryland			STATE							
24. FUNERAL DIRECTOR Troyon Wheeler Funeral Home, Inc. 1391 Rockville Pike, Rockville, Md. 20852						25a. DATE REC'D. BY REGISTRAR DEC 20 1985			25b. REGISTRAR'S SIGNATURE John K. Anderson, Jr.										

660866



357051

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 3 5 3 4 0

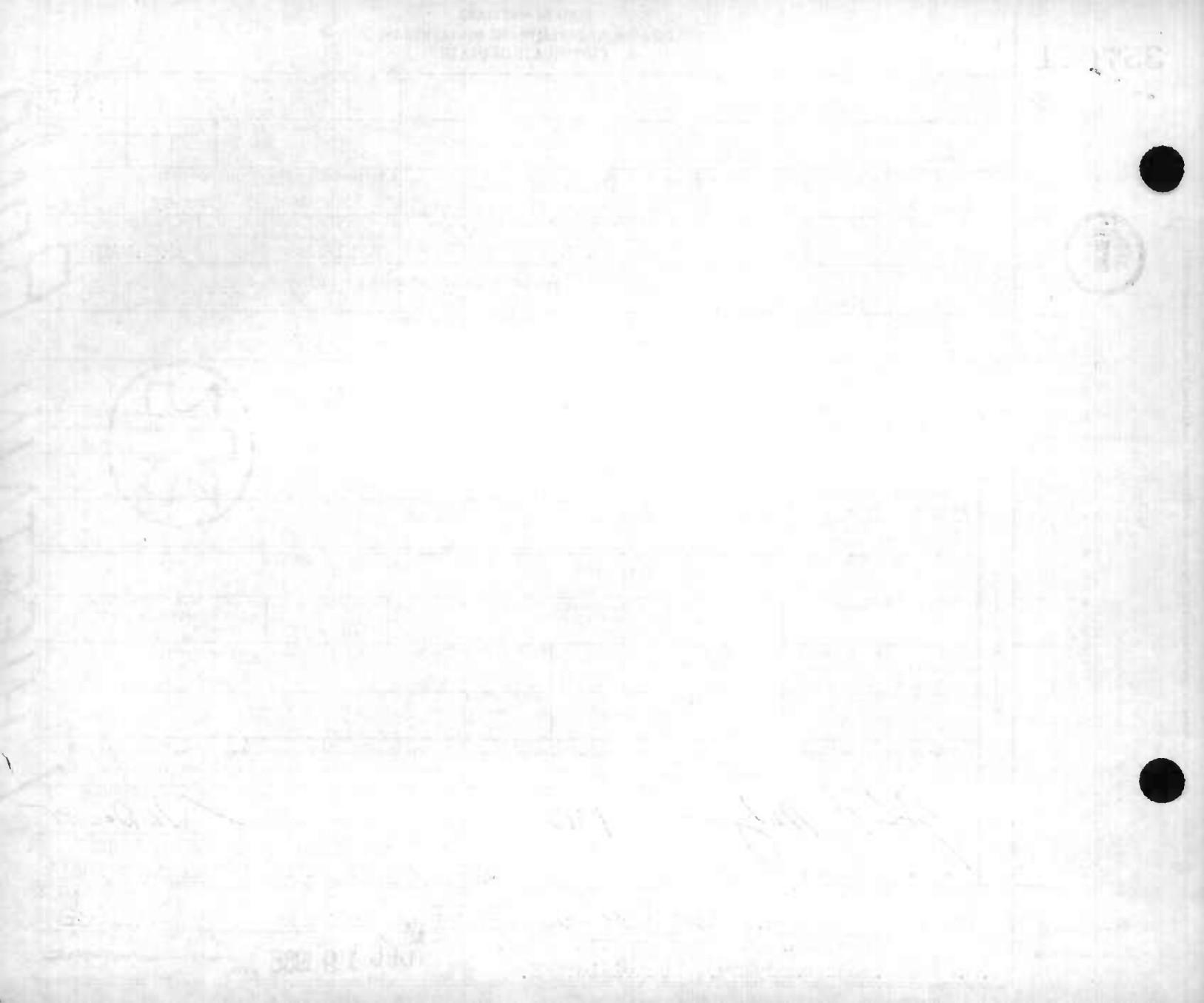
1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME      FIRST      MIDDLE      LAST				2a. DATE OF DEATH      MONTH      DAY      YEAR				2b. HOUR											
JOHN ROBERT WALKER				DECEMBER 15 1985				9:10 P M											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR											
MALE		CAUCASIAN		MAY 5 1927		58		MONTHS    DAYS											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
MISSOURI		UNITED STATES		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		MONTGOMERY County		BETHESDA		NAVAL HOSPITAL		RETIRER		U.S.NAVY					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
MARYLAND				MONTGOMERY		ROCKVILLE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14817 BAUER DRIVE 20853		John Reginald WALKER		MARY EVELYN HOLMAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
YES				1949-1979		494-20-9138 Colleen Walker, 14817 BAUER DRIVE, ROCKVILLE, MD		(b)		(c)									
19. DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  (b)  (c)												DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 12, 1985, to DECEMBER 15, 1985, that (I) (we) lost saw the deceased alive on DECEMBER 15, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <i>16 Dec 85</i>							
22b. SIGNATURE <i>J. P. Mehegan</i>			22d. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>													
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. P. MEHEGAN, LT, MC, USNR</b>			22f. ADDRESS NAVAL HOSPITAL NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814							23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Dec. 19, 1985		23c. NAME OF CEMETERY OR CREMATORIUM Cemetery		23d. LOCATION CITY OR TOWN Arlington		COUNTY STATE Virginia	
24. FUNERAL DIRECTOR NAME P.A. 300 W. Montgomery Av., Rockville, Md.			25a. DATE REC'D. BY REGISTRAR DEC 19 1985			25b. REGISTRAR'S SIGNATURE <i>J. P. Mehegan</i>													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



365108

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 3 5 3 4 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 1 and 2 of 2 will be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
MYRTLE NICHOLS WALKER						DECEMBER 20 1985				8:05 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
FEMALE		Caucasian		MARCH 20 1905		80		MONTHS DAYS		HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
SOUTH CAROLINA		UNITED STATES				MONTGOMERY County,					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BETHESDA		NAVAL HOSPITAL		Spinner		TEXTILE S					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13e. STREET ADDRESS / ZIP CODE					
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		2322 McCORMICK RD. 20850					
14. FATHER'S NAME FIRST TOM		MIDDLE BELL		LAST NICHOLS		15. MOTHER'S MAIDEN NAME FIRST AMANDA		MIDDLE JANE		LAST DILLINGHAM	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
NO		250-16-0791		OSCAR B. WALKER		2322 McCORMICK RD. ROCKVILLE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
RESPIRATORY FAILURE											
DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last											
{ (b)  DUE TO, OR AS A CONSEQUENCE OF  (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 18 1985 to DECEMBER 20 1985, that (I) (we) last saw the deceased alive on DECEMBER 20 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>J. M. Guinee</i>						DEGREE		22c. DATE SIGNED DEC 21, 1985			
MD						ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN X					
J. M. GUINEE, LT, MC, USNR						22d. ADDRESS NAVAL HOSPITAL, NMC NCR, BETHESDA, MD 20814-5011					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE December 23, 1985		23c. NAME OF CEMETERY OR CREMATORIUM Beersheba Presbyterian Church Cemetery		23d. LOCATION CITY OR TOWN York		CITY OR TOWN YORK CO. S. CAROLINA		STATE	
Burial											
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., 7557 Wisconsin Ave., Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR JUL 27 1985		25b. REGISTRAR'S SIGNATURE <i>J. M. Guinee</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked out, items 18 showing injury, or other traumatic event, the medical examiner must be notified at once.

365220

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 3 5 3 4 2

1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR										2b. HOUR	
I. DECEASED NAME FIRST MIDDLE LAST			December 20, 1985										9:44a m	
3 SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 24 HRS				
Female		White		Feb. 5, 1900			85 YRS			MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH							
Russia		U.S.A.					Montgomery County, MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Bethesda		Suburban Hospital		Housewife			-----							
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE							
Maryland		Montgomery		Potomac			11316 Willowbrook Drive (20854)							
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
Benjamin		Kotz		Anna			Rubin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS							
NO		577-58-1098		Sheldon A. Wallerstein; 11316 Willowbrook Dr.			Potomac, Md. 20854							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
18. CAUSE OF DEATH (Enter only one cause per line for 18, 19, and 20) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>														
DUE TO, OR AS A CONSEQUENCE OF (b) <i>atherosclerotic heart disease</i>														
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 12-7, 1985, to 12-20, 1985, that (I) (we) lost sow the deceased alive on 12-20, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Donald R. Bucy</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Dec. 20, 1985							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD BUCY, M.D.		22e. ADDRESS 809 Viers Mill Rd.; Rockville, Md. 20851												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/22/85		23c. NAME OF CEMETERY OR CREMATORIAL King David Mem. Gdn.			23d. LOCATION CITY OR TOWN Falls Church; Fairfax; Va.							
24. FUNERAL DIRECTOR NAME DAN ZANSKY-GOLDBERG MEMORIAL CHPL. 1170 Rockville Pike; Rockville, Md.														
25a. DATE REC'D. BY REGISTRAR DEC 23 1985 25b. REGISTRAR'S SIGNATURE <i>Julie Davidson Pendell</i>														



large white  
soft body



006215

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 5 3 4 3

REG. NO.

1 - FOR  
STATE  
REGISTRAR

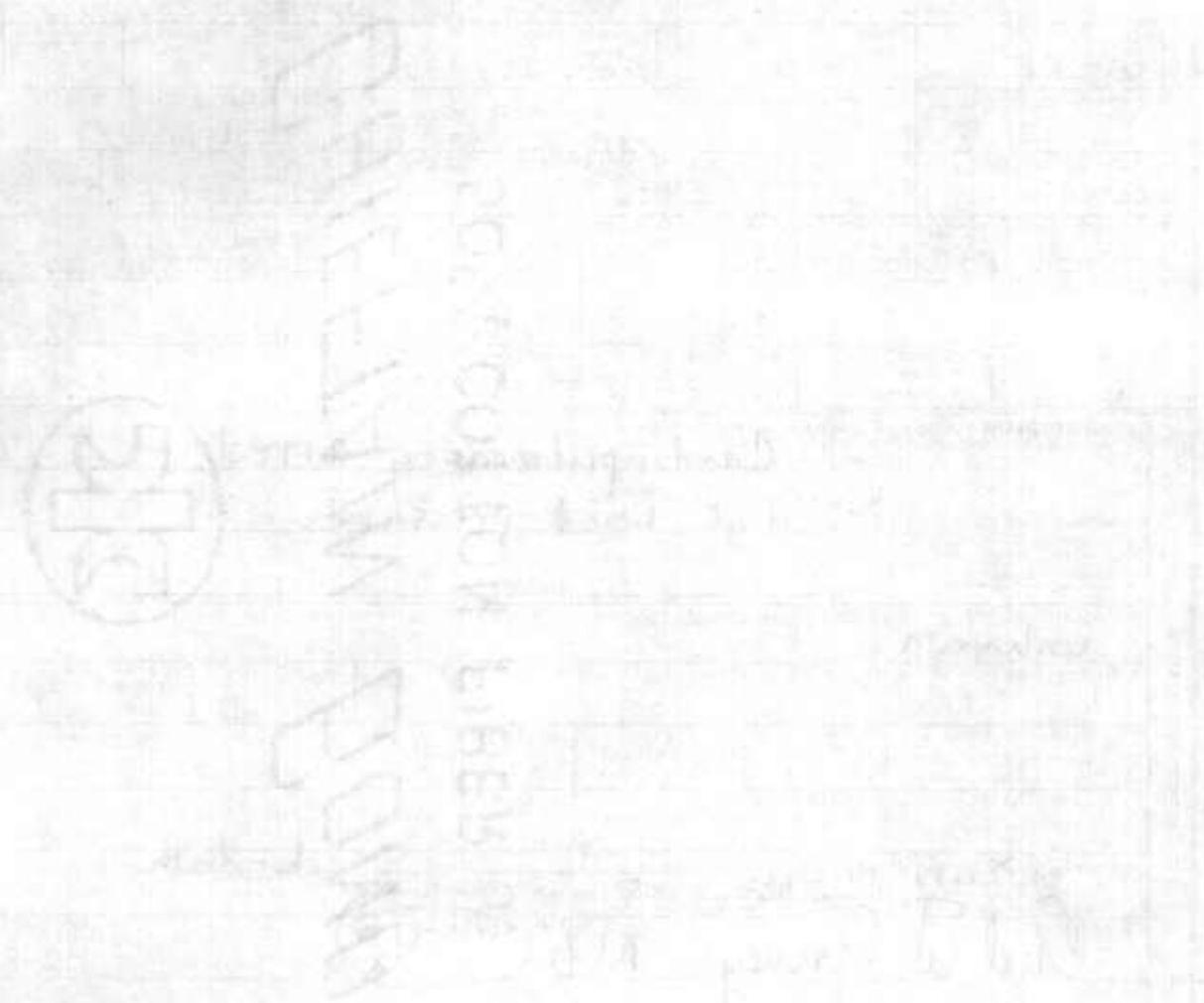
1 DECEASED NAME FIRST MIDDLE LAST				2a DATE OF DEATH MONTH DAY YEAR	2b HOUR
MOLLIE B. WARD				December 26, 1985 6:15pm	
3. SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 12, 1902	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b CITIZEN OF WHAT COUNTRY? USA		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7c CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6111 Montrose Road		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville					
13d. INSIDE CITY LIMITS? YES XX NO <input type="checkbox"/>					
13e. STREET ADDRESS / ZIP CODE 6111 Montrose Rd., 20852					
14. FATHER'S NAME FIRST Joseph MIDDLE Bluemen LAST		15. MOTHER'S MAIDEN NAME FIRST Chiah MIDDLE Leah LAST (unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 415-18-9221		17. INFORMANT ADDRESS David Goldman; 224 Southgate Dr., Northbrook	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) High blood pressure.					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a unknown					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO X 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that the hospital informed the deceased from now the deceased alive on NOVEMBER 19 85 and that in my own opinion death occurred on the date and hour and from the causes stated above. I (did) and (did) not view the body after death.					
22b. SIGNATURE CAROL W. GARVEY, M.D.		22c. DEGREE DOCTOR OF MEDICAL PHYSICIAN <input checked="" type="checkbox"/> ATTENDING DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 12-27-1985	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) CAROL W. GARVEY, M.D.		22f. ADDRESS 11510 Old Georgetown Road, Rockville Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-27-1985		23c. NAME OF CEMETERY OR CREMATORIUM King David Mem. Gdn	
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels, 1170 Rockville Pike		ADDRESS Rockville, Md.		25a. DATE DEP'D. OR REGISTER'D. DEC 31 1985 25b. REGISTRAR'S SIGNATURE Julie Leidner Bender	

TO HOSPITAL OR REFERRING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon copy and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event,

615.00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 3535344

1. DECEASED NAME (TYPE OR PRINT) <b>NONIE</b>			FIRST <b>Nonie</b>	MIDDLE <b>Emily</b>	LAST <b>Warren</b>	2a. DATE OF DEATH <b>12-3-85</b>	MONTH <b>Dec</b>	DAY <b>9</b>	YEAR <b>1985</b>	2b. HOUR <b>11:00 P.M.</b>
3. SEX <b>Female</b>			4 RACE <b>White</b>	5. DATE OF BIRTH <b>09 23 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b>	IF UNDER 1 YEAR MONTHS <b>YRS</b>		IF UNDER 24 HRS HOURS <b>MIN.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Alabama</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>				
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Heritage Health Care</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>P.G.</b>	13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>2316 Lewisdale Dr. 20783</b>			
14. FATHER'S NAME FIRST <b>Thomas</b>			MIDDLE <b>J.</b>	LAST <b>Willis</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Sarah</b>		MIDDLE <b></b>	LAST <b>White</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>217-52-7243</b>			17. INFORMANT <b>Aubrey M. Warren (Son)</b>	ADDRESS <b>2316 Lewisdale Drive Hyattsville, Md. 20783</b>			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Aspiration pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>C.V.H., Coronary Artery disease</i>										
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Diabetes b.g.</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		21g. CITY OR TOWN	21h. COUNTY	21i. STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>11/20/82</b> to <b>12/14/85</b> , to <b>1982</b> , that (I) (we) last saw the deceased alive on <b>11/20/85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>R. Bell</i>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED <b>12/4/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VIVEK C VAID M.D.</b>			22e. ADDRESS <b>7676 New Hampshire Ave Langley Park, Md 20783</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>12/7/85</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Providence Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Glenwood</b>	23e. COUNTY <b>Crenshaw</b>	23f. STATE <b>Alabama</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Funeral Home, P.A.</b>			25a. DATE REC'D. BY REGISTRAR <b>DEC 9 1985</b>			25b. REGISTRAR'S SIGNATURE <i>Gene Burson</i>				
DHHM - 16 60M 7/84 (VRA 15, 4)										

111816

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial/transit report. Then please send carbon copies. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

IMPORTANT: If item 21 is marked or item 22 is shown any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	5	3	5	3	4	5
												REG. NO.						
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
Nathan			L.	Waters		December 16, 1985						6:10 a.m.						
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR						
Male			Black			Sept. 28, 1911			74			IF UNDER 24 HRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
MD			USA						MONTGOMERY			MD.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Oney			Montgomery General Hospital			Custodian			Naval Med. Ctr.									
13a. STATE			13b. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE									
MD			Montg.			Gaithersburg			7929 Spiceberry Cir. #H/20877									
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST						
Nathan E. Waters						Amanda Potts												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS									
No			218-01-5818			Marie A. Waters (Wife) same as #13												
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiogastroenteritis</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12/16/85</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <i>Tumour cancer c metast</i>												<i>12/3/85</i>						
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>CAD</i>																		
19a. DATE OF OPERATION <i>9/8/85</i> <i>10/17/85</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Recurvirostra - rectal polypoid lesions</i> <i>@ Thrombolytic therapy - CT scan</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE						
22a. I certify that (I) (we) attended the deceased from <i>12/13</i> , 19 <i>85</i> , to <i>12/16</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>12/15</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (not) view the body after death.												22b. SIGNATURE <i>Michael Bolognese</i>						
22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												22d. DATE SIGNED <i>12/16/85</i>						
22e. ADDRESS <i>1811 Penn Philip Dr., Rockville, MD 20852</i>																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-21-85			23c. NAME OF CEMETERY OR CREMATORIUM Emory Grove Cemetery			23d. LOCATION CITY OR TOWN Gaithersburg, Montg. MD			COUNTY STATE						
24. FUNERAL DIRECTOR NAME George R. Snowden			246 N. Washington Street Rockville, MD 20850			25a. DATE REC'D. BY REGISTRAR DEC 20 1985			25b. REGISTRAR'S SIGNATURE <i>John K. B. Bolognese</i>									

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105201 105201 105201 105201 105201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be consulted.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 358022
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH DAY YEAR
1 DECEASED NAME (TYPE OR PRINT)			MARGARET C. WATKINS			12 18 85
3. SEX <b>Female</b>			4 RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 6, 1914</b>
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b CITIZEN OF WHAT COUNTRY? <b>USA</b>			6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS
10 CITY OR TOWN OF DEATH <b>OLNEY</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MONTGOMERY GENERAL HOSPITAL</b>			7b HOUR 10:50p
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD.</b>
13c. CITY OR TOWN <b>Clarksburg</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>
14 FATHER'S NAME FIRST <b>E.</b>			MIDDLE <b>Wilfred</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Hardware Store</b>
LAST <b>Runkles</b>			15 MOTHER'S MAIDEN NAME FIRST <b>Martha</b>			MIDDLE <b>D.</b>
LAST <b>Suman</b>						LAST
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-46-6686</b>			17 INFORMANT <b>Wayne S. Watkins, Ijamsville, Md. 21770</b>
						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			RESPIRATORY FAILURE SECONDARY TO			
DUE TO, OR AS A CONSEQUENCE OF (b) <b>SEPTICEMIA. DUE TO RECURRENT DIFFUSE</b>						
DUE TO, OR AS A CONSEQUENCE OF (c) <b>HISTIOCYTIC LYMPHOMA. GRANULOCYTOPENIA.</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) <b>this hospital</b> attended the deceased from <b>June 19, 85</b> to <b>Dec 18, 1985</b> , that (I) <b>last</b> saw the deceased alive on <b>Dec 19, 85</b> , and that in (my) <b>last</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>did</b> (did not) view the body after death.						
22b. SIGNATURE <b>Donald E. Dillon, M.D.</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Donald E. Dillon, M.D.</b>		22e. ADDRESS <b>2901 Olney-Sandy Spring Rd., Olney, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 21, 1985</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Mountain View</b>		23d. LOCATION CITY OR TOWN <b>Damascus, Montgomery, Md.</b>
24. FUNERAL DIRECTOR <b>Olyn L. Molesworth, P.A., Damascus, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>DEC 20 1985</b> 25b. REGISTRAR'S SIGNATURE <b>John Anderson Pendell</b>				
DHMH - 16 60M 7/84 (VRA 15, 4)						



008018

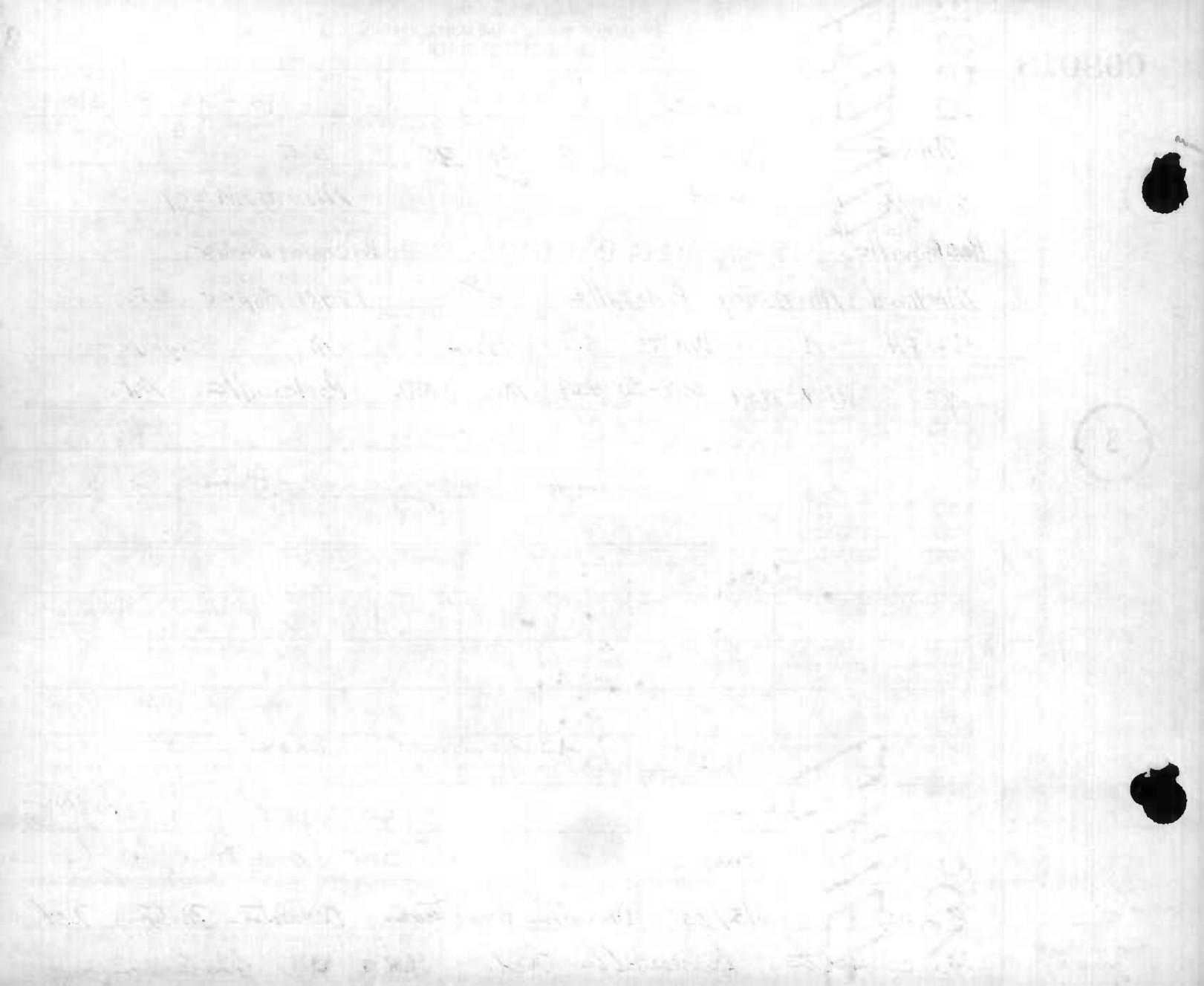
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked as Item 18 shows any injury or other traumatic event, the medical examiner shall be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										5 35341					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
<i>Robert Lee</i>					<i>Watts</i>	<i>12-26-85</i>					55	610 PM			
3. SEX			4. RACE		5. DATE OF BIRTH			MONTH	DAY	YEAR	6 AGE (IN YEARS LAST BIRTHDAY)				
<i>MALE</i>			<i>White</i>		<i>3 29 80</i>			<i>30</i>	<i>YEAR</i>	<i>55</i>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
<i>Maryland</i>			<i>USA</i>		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<i>Montgomery</i>							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
<i>Rocksburg</i>			<i>Shady Grove Adventist. Hosp., Purchasing Manager</i>										12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
<i>Maryland</i>			<i>Montgomery</i>		<i>Poolesville</i>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			<i>17401 Super St. 20837</i>				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	ADDRESS			
<i>RALPH</i>			<i>C.</i>		<i>Watts Sr.</i>	<i>Flora</i>			<i>M.</i>		<i>Synder</i>	<i>Poolesville Md.</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (# YES, GIVE WAR OR DATES)			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
yes			<i>1951-1954</i>			<i>Mrs. Watts</i>			<i>17 hrs</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>															
DUE TO, OR AS A CONSEQUENCE OF (b) <i>George Conway City Disease</i>															
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Obesity</i>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Obesity</i>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <i>12/26 1985</i> to <i>12/26 1985</i> , that (I) (we) last saw the deceased alive on <i>12/26 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>D. Goldman</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>12/26/85</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Donald Goldman</i>			22e. ADDRESS <i>13-15 East Deer Park, Dr., Gaithersburg</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>12/30/85</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Bethesda Presbyterian</i>			23d. LOCATION CITY OR TOWN <i>Bethesda</i> COUNTY <i>Maryland</i> STATE <i>DC</i>						
24. FUNERAL DIRECTOR NAME <i>W. C. Helm</i>			ADDRESS <i>Bethesda Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>JAN 3 1986</i>			25b. REGISTRAR'S SIGNATURE <i>Julian Wilson-Brown</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked "No", it shows any injury, or other traumatic event, the medical examiner will not be called.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 35348											
1. FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR		
			Alvin F. Weber						Dec. 28 1985		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male			White			Sept. 25 1930			55 yrs.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
Washington, D.C.			USA								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			3618 Randolph Road			Operating Engr.			D.C. Govt.		
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
									13e. STREET ADDRESS / ZIP CODE 3618 Randolph Rd. 20902		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
John F. Weber			Marie Ella Schmitt								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR ORDATES) 1951-1955			17. INFORMANT Joyce E. WEBER - wife - (same as 13e)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, b, and c) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i>			DUE TO, OR AS A CONSEQUENCE OF (b) <i>lung cancer</i>						1 year		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 19 85</u> to <u>12/20 85</u> , that (I) (we) last saw the deceased alive on <u>Nov 19 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Frederick G. Barr, MD.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/30/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick G. Barr, MD			22e. ADDRESS 106 Irving St., N.W. #421 Wash., DC								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-31-1985			23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.		
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home			11800 N.H. Ave. Silver Spring, Md.			25a. DATE REC'D. BY REGISTRAR DEC 31 1985			25b. REGISTRAR'S SIGNATURE <i>Hines/Rinaldi</i>		
BP _____											
DHMH - 16 50M 4/83 (VRA 15, 4)											



1 - FOR  
STATE  
REGISTRATION

REF ID: NC

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	REG. NO.	26. HOUR 145 P.M.				
Ima Jewel Weideman						20. DATE OF DEATH	MONTH	DAY	YEAR		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Caucasian		Oct. 22, 1922		63		MONTHS		DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Texas		United States				Montgomery County, MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY					
Kensington		Sylvan Manor Health Center		Secretary		HEW					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS / ZIP CODE			
Maryland		Montgomery		Rockville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4427 Faroe Place		20853	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
FIRST Hubert			MIDDLE Ross			FIRST Rockie			MIDDLE LAST White		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		Son		ADDRESS			
No		455-24-6988		Dwain Shankel		14224 Chadwick Lane		Rockville, Md		20853	
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, etc.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Breast Cancer</i> 2 1/2 yrs											
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause first.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I o											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a I certify that (I) (this hospital) attended the deceased from <i>10 Aug 85</i> , 19 <i>85</i> , to <i>12 Oct 85</i> , 19 <i>85</i> , that (I) (we) lost sow the deceased alive on <i>12 Oct 85</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death.											
22b. SIGNATURE <i>E.P. Libre</i>		22c. DEGREE <i>M.D.</i>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED December 12, 1985					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eugene P. Libre, M.D.				22e. ADDRESS 10400 Connecticut Avenue Kensington, Maryland 20895							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Dec. 14, 1985		23c. NAME OF CEMETERY OR CREMATORIUM Parklawn Memorial Park		23d. LOCATION CITY OR TOWN Rockville		COUNTY		STATE Maryland	
24. FUNERAL DIRECTOR NAME P.A., 300 W. Montgomery Ave., Rockville, MD.		ADDRESS Robert A. Pumphrey Funeral Homes,		25a. REC'D. BY REGISTRAR DEC 10 1985		25b. REGISTRAR'S SIGNATURE <i>John Pendle</i>					

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The [redacted] retained by the hospital or attending physician

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and/or hospital staff in the funeral director's presence, it should be filed within 72 hours after death should be detached for use at the burial/entombment permit. Then please remove carbon copy and remove with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP \_\_\_\_\_  
HMH - 16 60M 7/84  
(VRA 15 1)

44-9528



200

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

35350  
REG. NO.

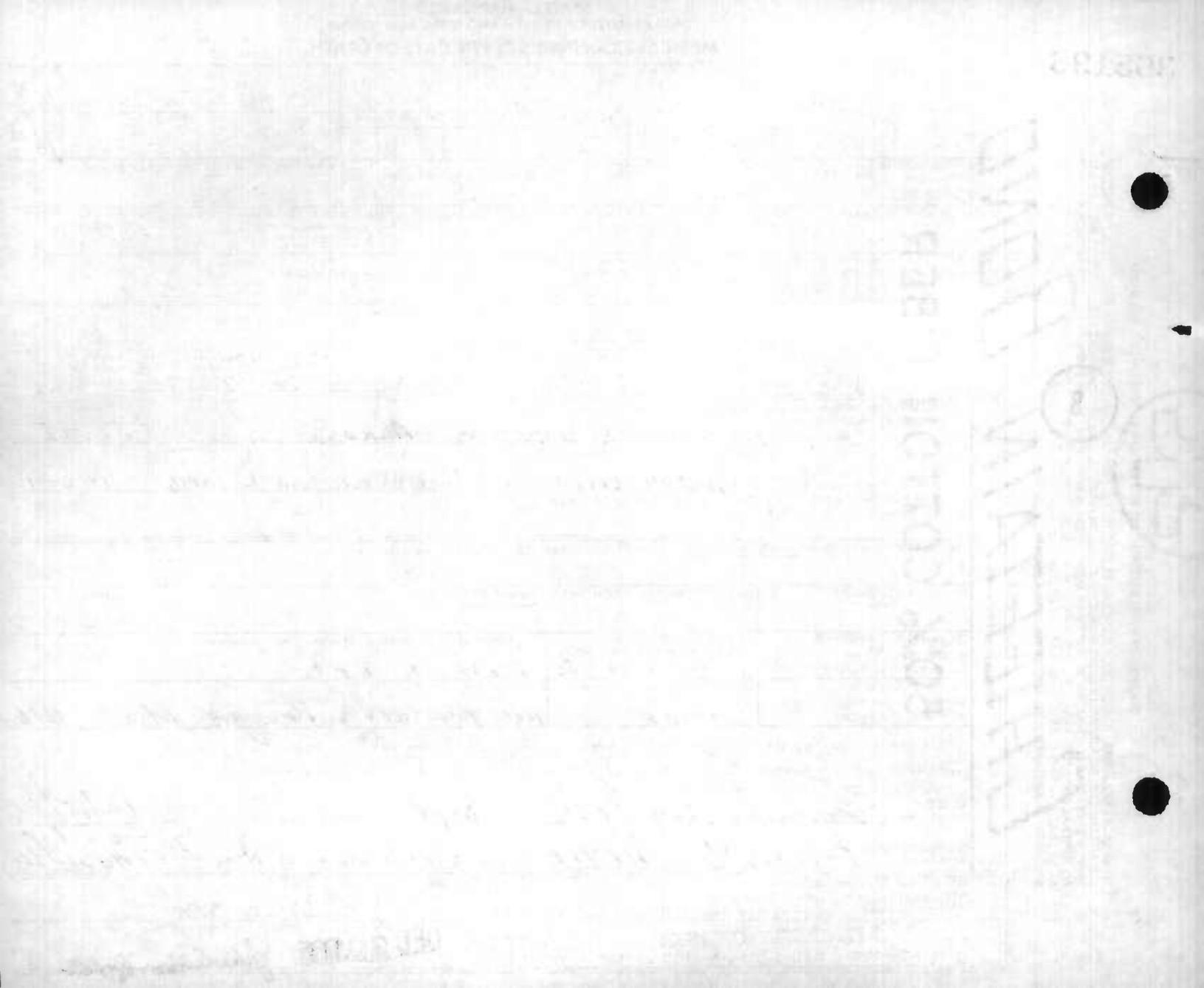
365196

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN IT. PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH A COPY OF THE DEATH RIBBON BM. 3. RETAIN PAGE 5 FOR YOUR FILES.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR
			HARRY	S	WENDER	<input checked="" type="checkbox"/>	12	14	85	16 38 M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
MALE	CAU.	Feb. 7, 1908	77 yrs.	MONTHS	DAYS	12	14	85	16 38 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH			
Tennessee		U.S.A.			<input type="checkbox"/> NEVER MARRIED	<input type="checkbox"/> DIVORCED	MONTGOMERY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BETHESDA		SUBURBAN HOSPITAL			Attorney		Law			
13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 10500 ROCKVILLE PIKE				
14. FATHER'S NAME FIRST WOLF		MIDDLE B.	LAST WENDER	15. MOTHER'S MAIDEN NAME FIRST ROSE		MIDDLE	LAST	STERN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Philadelphia, PA 19116				
NO		577-54-0777		Marilyn Wender Cohen; 13498 Proctor Rd.;						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
					<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12 14 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>DIED IN BED</u>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>HOME</u>		21f. LOCATION STREET 10500 Rockville Pike, Rockville, Mont. 20852		CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>Francis C. Mayle</u>		TITLE (SPECIFY) M.D. <u>Dept</u>			MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT) <u>Francis C. Mayle</u>		ADDRESS <u>see Wisconsin Ave Bethesda Md.</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/17/85		23c. NAME OF CEMETERY OR CREMATORIAL Lee Crematory		23d. LOCATION CITY OR TOWN Washington, D.C.		STATE		
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHPLS. 1170 Rockville Pike, Rockville, Md. 20852					25a. DATE REC'D. BY REGISTRAR DEC 20 1985		25b. REGISTRAR'S SIGNATURE <u>Julia Davis - Director</u>			

ERIKSEN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the hospital or attending physician.

346135  
 by the funeral director, page 3  
 filled with 72 hours after death  
 by the medical examiner, page 4  
 filled with 72 hours after death. Page 4 may be  
 filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 35651	
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Marie M. Wendler						12 06 85			2310M	
3. SEX			4 RACE White			5. DATE OF BIRTH MONTH 11 DAY 26 YEAR 18			6. AGE (IN YEARS LAST BIRTHDAY) 67 1/4 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery			MD.	
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary Insurance Co.			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Md.			13b. COUNTY Carroll			13c. CITY OR TOWN Mt. Airy			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 5321 Pommel Drive 21771	
14. FATHER'S NAME FIRST Antone			MIDDLE Matysek			15. MOTHER'S MAIDEN NAME Barbara							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 217-05-2611			17. INFORMANT Mr. Howard J. Wendler			ADDRESS 21771				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) multiple organ failure													
DUE TO, OR AS A CONSEQUENCE OF (c) gastro intestinal hemorrhage													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Crohn's disease; Chronic renal failure													
19a. DATE OF OPERATION 12/4/85			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED gastro intestinal hemorrhage			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IE EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2) at home							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 10-21, 1985, to 12-6, 1985, that (I) (we) last saw the deceased alive on 12-6, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 12/7/85	
22b. SIGNATURE Robert L. Fox			22d. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Robert L. Fox			22f. ADDRESS 1811 Prince Philip Dr., Olney, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 10, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn			23d. LOCATION CITY OR TOWN Woodlawn			COUNTY Balto. Md. STATE	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland			ADDRESS			25a. DATE REC'D. BY REGISTRAR DEC 10 1985			25b. REGISTRAR'S SIGNATURE Janine Anderson-Ruck Inc.				

60 hours

1950 - 1951 January 1951

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event January 1951 no. 1950-51

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but detail, which will now have to be transcribed

347078

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
BESS					WESLEY	December 4, 1985			10:20 <sup>p.m.</sup>		
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE   IN YEARS LAST BIRTHDAY			IF UNDER 1 YEAR   IF UNDER 24 HRS:		
Female		White	Jan. 18, 1895			90			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Montgomery MD.		
Missouri		USA									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		1131 University Blvd. West			Housewife			-----			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Maryland		Montgomery	Sil. Spg.						1131 University Blvd West 20902		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
		Joseph		Kretchmar	Anna			1 year			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>		
NO		-----		497-05-2522							
b) <i>arteriosclerotic heart disease</i>		DUE TO, OR AS A CONSEQUENCE OF						years			
c) <i>Hypertension</i>		DUE TO, OR AS A CONSEQUENCE OF						years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>ischemic colitis</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>OCT 22, 1985</u> to <u>Dec 4, 1985</u> , that (I/we) last saw the deceased alive on <u>Dec 2, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did/did not view the body after death.											
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						12-5-1985			
MORTON W. SHAPIRO, M.D.		5225 Pooks Hill Road; Bethesda, Md.						20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN			23d. LOCATION CITY OR TOWN		23e. COUNTY STATE		
Burial		12-6-1985		King David Mem. Gdn.			Falls Church, Virginia				
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels: 1170 Rockville Rd.		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Danzansky-Goldberg Chapels: 1170 Rockville Rd.											

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270746



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 more  
than 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed and asked

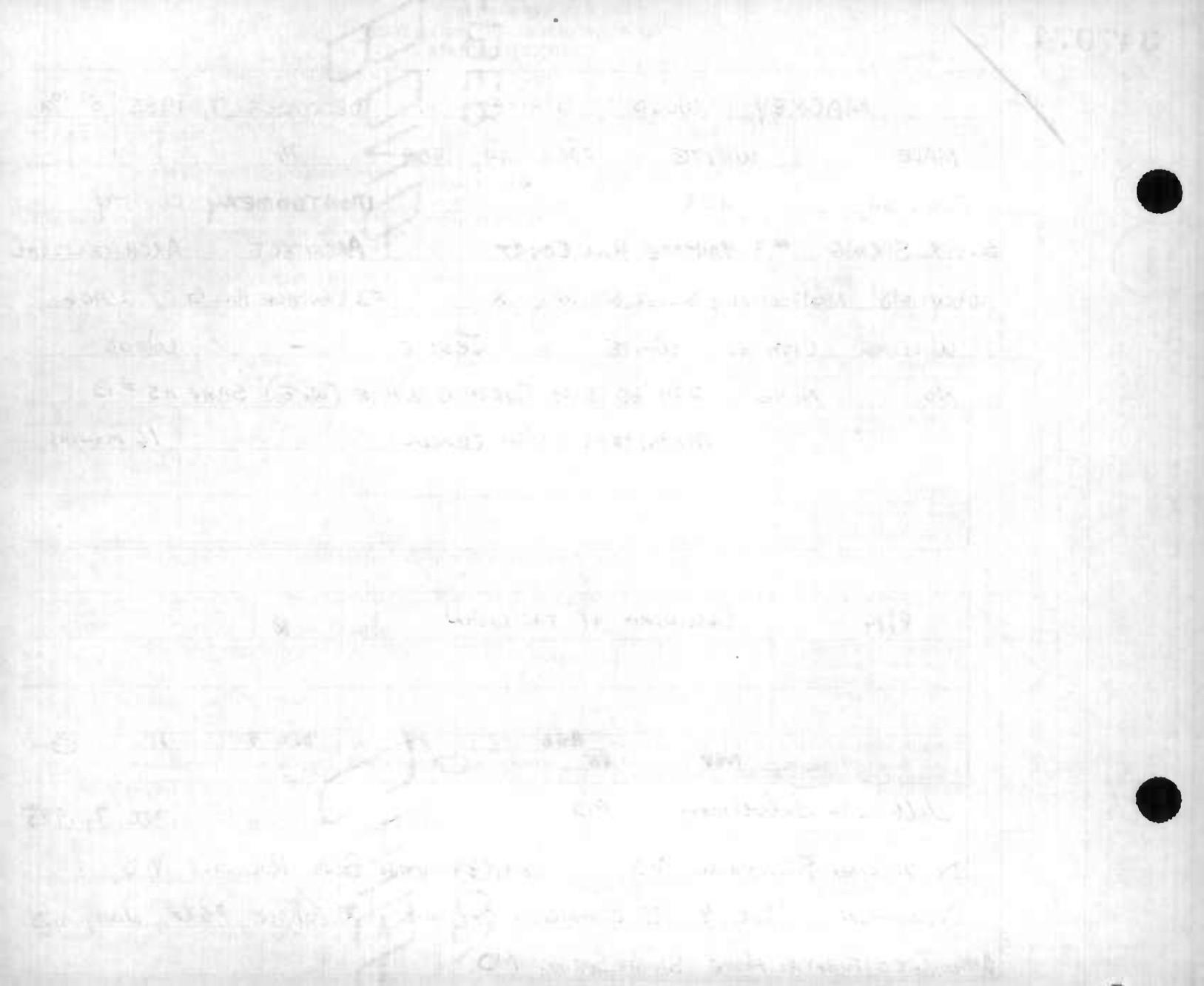
347074

1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

5 3 5 3 5 3

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
						DECEMBER	7	1985		8:20 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE		WHITE		APRIL 24, 1909		76 YRS.		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
FLORIDA		USA				MONTGOMERY COUNTY							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
SILVER SPRING			#3 VANTAGE Hill COURT						ARCHITECT			ARCHITECTURAL	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
MARYLAND			MONTGOMERY		SILVER SPRNG				#3 VANTAGE HILL CT. / 20906				
14. FATHER'S NAME FIRST			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
WILLIAM			CHARLES		WHITE		JESSIE		—		Wood		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. IMMEDIATE CAUSE (a)		17. INFORMANT		ADDRESS				
NO			None		224-60-2039		Florence White (Wife) SAME AS #13		16 MONTHS				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic colon cancer												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION 8/84			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA OF THE COLON						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from AUG 19 84 to DEC 7 19 85, that (I) (we) last saw the deceased alive on NOV 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												22c. DATE SIGNED DEC 7, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William Silverman			MD DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS 6111 EXECUTIVE BLVD. ROCKVILLE, MD.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE DEC 9, 1985			23c. NAME OF CEMETERY OR CREMATORIAL CHAMBERS CREMATORIAL			23d. LOCATION CITY OR TOWN RIVERDALE, P.G.CO., Maryland		23e. DATE REC'D. BY REGISTRAR DEC 11 1985		
24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME			ADDRESS SILVER SPRING, MD.						25e. REGISTRAR'S SIGNATURE CHAMBERS				



357019

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3535

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
John G.				Wildensteiner	12	12	85		11:31PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				
Male		Caucasian		MONTH	DAY	YEAR	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS		
7b. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Washington, D.C.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery			MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Olney		Montgomery General Hospital		Baker			Charles Schneider Bakery			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		12823 Valleywood Drive 20906				
Maryland		Montgomery		Wheaton						
14. FATHER'S NAME		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
Konrad				Margaret				Tanner		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
Yes		WW II		578-09-1114		A. Rosa Wildensteiner Wife Same as 13				
18. CAUSE OF DEATH (Enter only one cause per line for item (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Dec 12, 1985, to Dec 12, 1985, that (I) (we) last saw the deceased alive on Dec 12, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (I) (we) did not view the body after death									22c. DATE SIGNED	
22b. SIGNATURE		22d. PHYSICIAN'S NAME (TYPE OR PRINT)			DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22e. ADDRESS			Dec. 13/1985
Gregory H. Fisher					MD		13-15 EAST DEER PK DRIVE Gaithersburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY STATE		
Cremation		Dec. 14, 1985		Metropolitan Crematory		Alexandria		Virginia		
24 FUNERAL DIRECTOR NAME		Francis J. Collins, Jr.		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
						DEC 19 1985		Lisa Henderson Pendall		
		500 University Blvd., W.		Silver Spring, Md.						

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21



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365169

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, an other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 5 3 5 3 5 4

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			Annie	V	Williams	12	11	85	6:45AM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Black		Sept. 20, 1928		57		MONTHS	YEARS	HOURS	MIN.
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Penn.		USA				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Olney		Montgomery General Hospital		Housewife							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE MD		13b. COUNTY Montg.		13c. CITY OR TOWN Silver Spring		13e. STREET ADDRESS 1007 Good Hope Drive/20904					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Reuben D. Reddix, Sr.			Sarah L. Walker								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 578-34-6779			17. INFORMANT Merlin C. William, Sr (Husband) same as #13			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cardiorespiratory arrest						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure						10 days		
			DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Carcinoma of Gall Bladder						5 months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Jala R. Reddix</i>		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 12/11/85					
22f. PHYSICIAN'S NAME (TYPE OR PRINT)		22g. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-17-85		23c. NAME OF CEMETERY OR CREMATORIAL Ash Memorial Cemetery		23d. LOCATION CITY OR TOWN Sandy Spring, MONTG		COUNTY		STATE MD	
24. FUNERAL DIRECTOR NAME George R. Snowden		24b. ADDRESS 246 N. Washington St. Rockville, MD 20850		24c. DATE REC'D. BY REGISTRAR DEC 20 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					



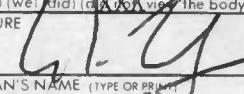
347015

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 3 5 5 0

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
Nancy			T		Winslow	December 6, 1985			9:15 a.m.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
Female			Caucasian			Month Day Year March 10, 1945			If Under 1 Year 40 Yrs.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Washington, D.C.			United States						Montgomery County		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Bethesda			NIH, The Clinical Center			Agent			Real Estate		
13a STATE			13b COUNTY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Maryland			Talbot			Newcomb			P. O. Box 9 21653		
14 FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			LAST		
John			D.			Ann			Sellers		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS		
No			215-44-2962			Mr. John Winslow, son			2424 Linden Ln. Silver Spring, Md 20910		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Lung Cancer APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (Years)											
DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			21g. CITY OR TOWN	21h. COUNTY	21i. STATE	
22a. I certify that <input checked="" type="checkbox"/> (his hospital) attended the deceased from April 24, 1985, to December 6, 1985, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive or <input checked="" type="checkbox"/> above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.											
22b. SIGNATURE 											
22c. DEGREE MD											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan T. Lefor, MD											
22e. ADDRESS National Institutes of Health, 9000 Rockville Pike, Bethesda, Maryland 20892											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Dec. 7, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory			23d. LOCATION CITY OR TOWN Alexandria		COUNTY		STATE Virginia
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. 7557 Wisconsin Ave. Bethesda, Maryland 20814		25a. DATE REC'D. BY REGISTRAR DEC 11 1985			25b. REGISTRAR'S SIGNATURE 						

BP \_\_\_\_\_

342072



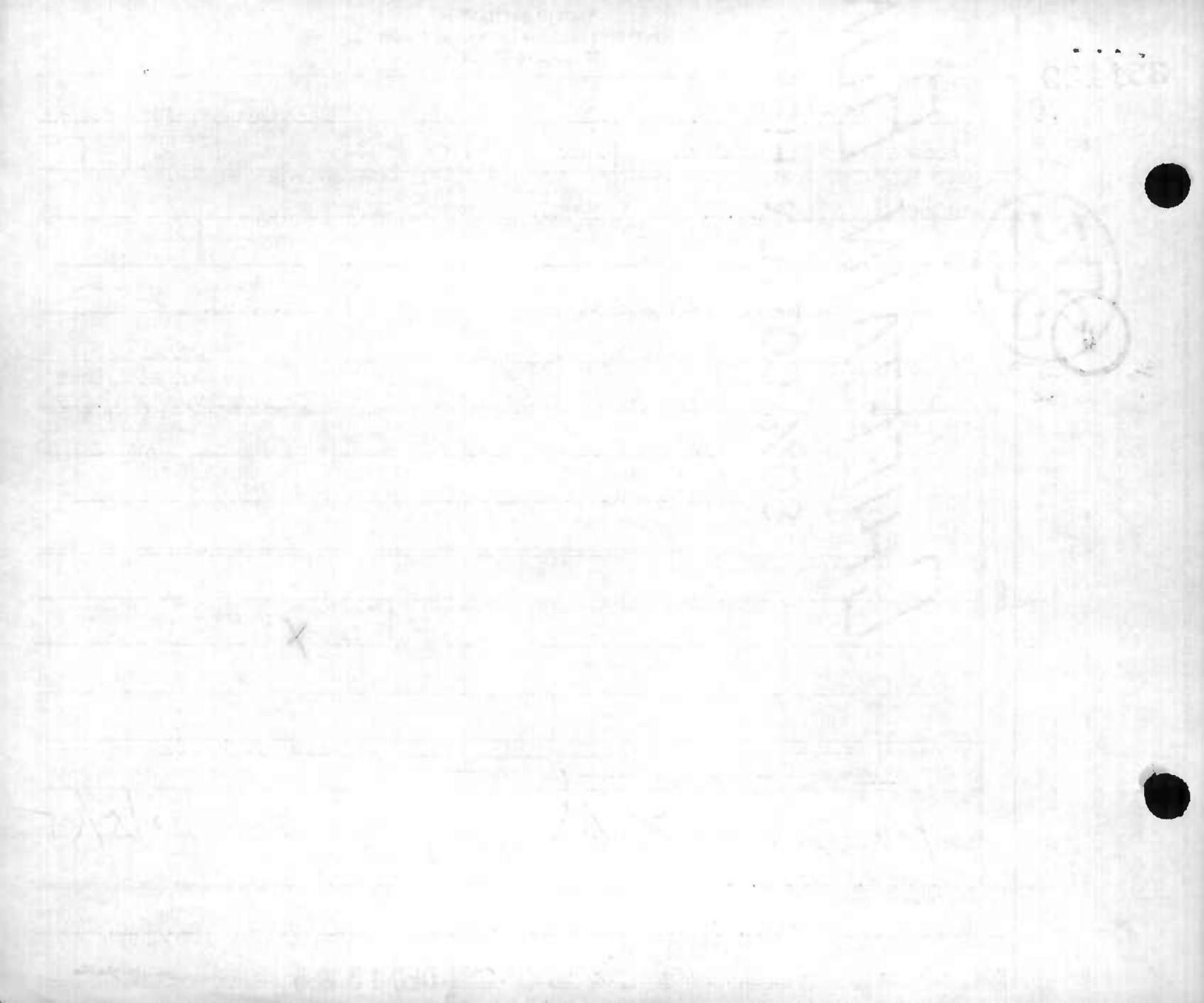
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be detached for use as the burial transit permit. Then please remove carbon papers. Page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 4 may be retained by the hospital or attending physician with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, an other traumatic event, the medical certification section must be completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						85 35351		
						REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Eleanor				December 4, 1985				9:20AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female	Caucasian	June 7, 1907		78	MONTHS	DAYS	HOURS	MIN.
YRS								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland	U.S.A.				Montgomery MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Silver Spring	Fairland Nursing Home				Adm. Clerk			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	12b. KIND OF BUSINESS OR INDUSTRY		
Maryland	Montgomery	Silver Spring	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1131 Univ. Blvd. West 20902	Aerospace Workers		
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE	LAST	
Earl				Mary				Harris
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.		17. INFORMANT	Niece	ADDRESS			
No	578-09-0058		Mary Martin		909 Windmill Lane Silver Spring, Md. 20904			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) <u>Cerebral Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours Years								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from Sept. 19 85 to December 4 19 85, that (I) <input checked="" type="checkbox"/> saw the deceased alive on December 3 19 85, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.								
22b. SIGNATURE <u>Thomas G. Ward, M.D.</u> DEGREE <u>MD</u>								
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DATE SIGNED <u>12/5/85</u>								
22c. ADDRESS <u>6116 Robinwood Road</u> <u>Bethesda, Maryland 20817</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE Burial Dec. 6, 1985	23c. NAME OF CEMETERY OR CREMATORIALy Cedar Hill Cemetery			23d. LOCATION Suitland	CITY OR TOWN County State		
24. FUNERAL DIRECTOR NAME	Francis J. Collins, Jr.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
500 University Blvd. W., Silver Spring, Md. 20901 DEC 13 1985								

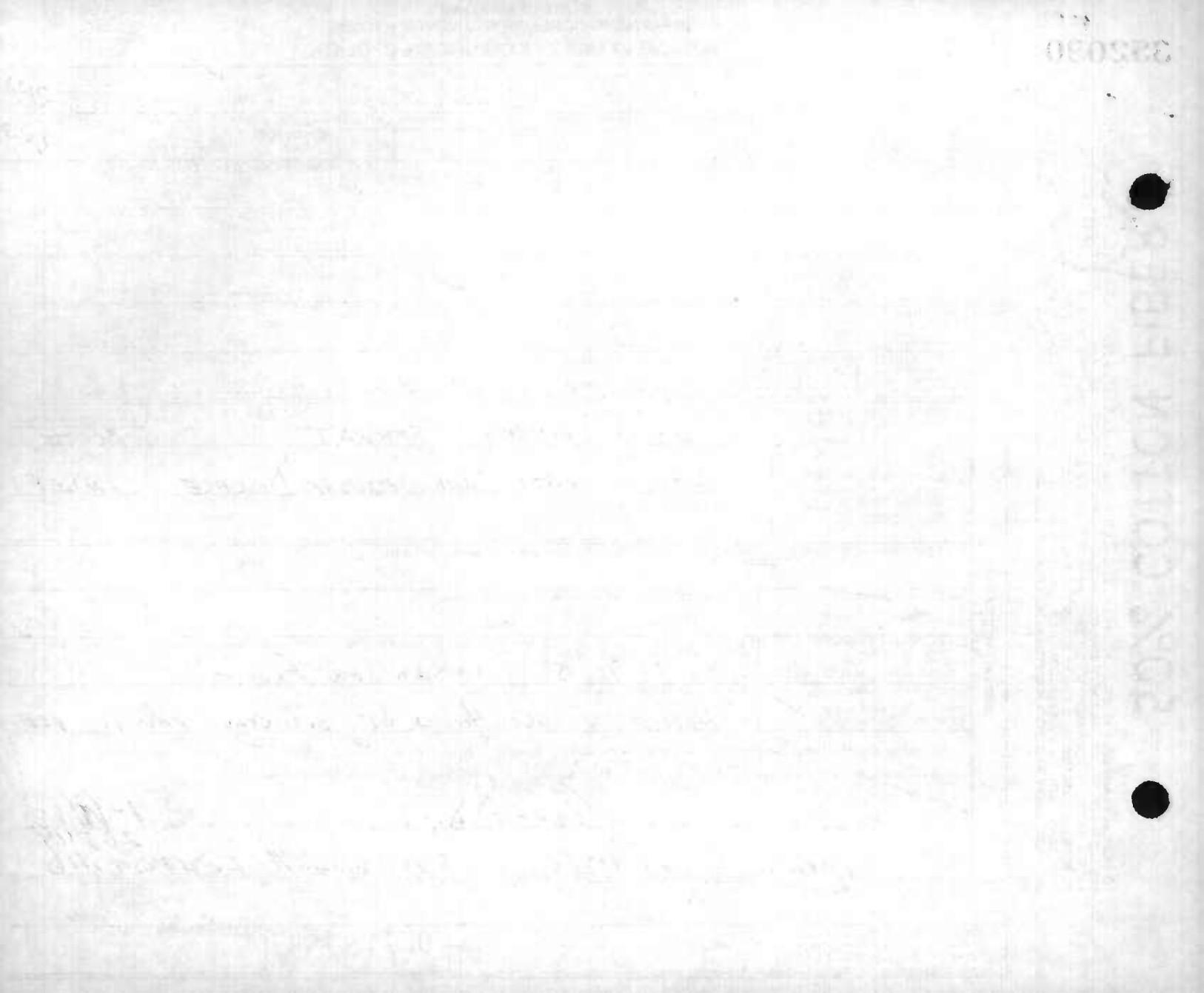


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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AN DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 35353											
1- STATE REGISTRAR			2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR 12/9 19 85									2b. HOUR 2123 M											
1. DECEASED NAME (TYPE OR PRINT) Adam John Wojciak, Jr.			MIDDLE			LAST			IF UNDER 1 YR. <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>			MONTH DAY YEAR											
1. SEX Male			4. RACE Cauc.			5. DATE OF BIRTH MONTH DAY YEAR 4/19/33			6. AGE IN YEARS (LAST BIRTHDAY) 52 yrs.			MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 12/9/ 19 85		2d. HOUR 2123 M							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montg County														
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney			12b. KIND OF BUSINESS OR INDUSTRY Montgomery County														
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Bethesda			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 5606 Hoover st 20817											
14. FATHER'S NAME FIRST Adam MIDDLE John LAST Wojciak, Sr.						15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE LAST Pajorski																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 1954-1956			17. INFORMANT Catherine R. Wojciak, same as #13			ADDRESS														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:												INDEF											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR 2005 P.M. 12 9 19 85			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) COLLAPSED ON FLOOR																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home			21f. LOCATION STREET 5606 Hoover St CITY OR TOWN BETHESDA COUNTY MONT. STATE MD																	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Francis C. Myhrle M.D. MEDICAL EXAMINER												DATE SIGNED 12/10/85											
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Myhrle			ADDRESS 820 Wisconsin Ave. Bethesda, MD 20814			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial									23b. DATE Dec 13, 1985			23c. NAME OF CEMETERY OR CREMATORIALY Arlington National			23d. LOCATION CITY OR TOWN Arlington COUNTY Virginia STATE		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes 7557 Wisconsin Ave. Bethesda, MD 20814 PA			25a. DATE REG'D BY REGISTRAR DEC 10 1985									25b. REGISTRAR'S SIGNATURE											
25c. REGISTRAR'S SIGNATURE																							

080520



006194

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 3 5 3 5 9

REG. NO.

1 - FOR  
STATE  
REGISTRAR

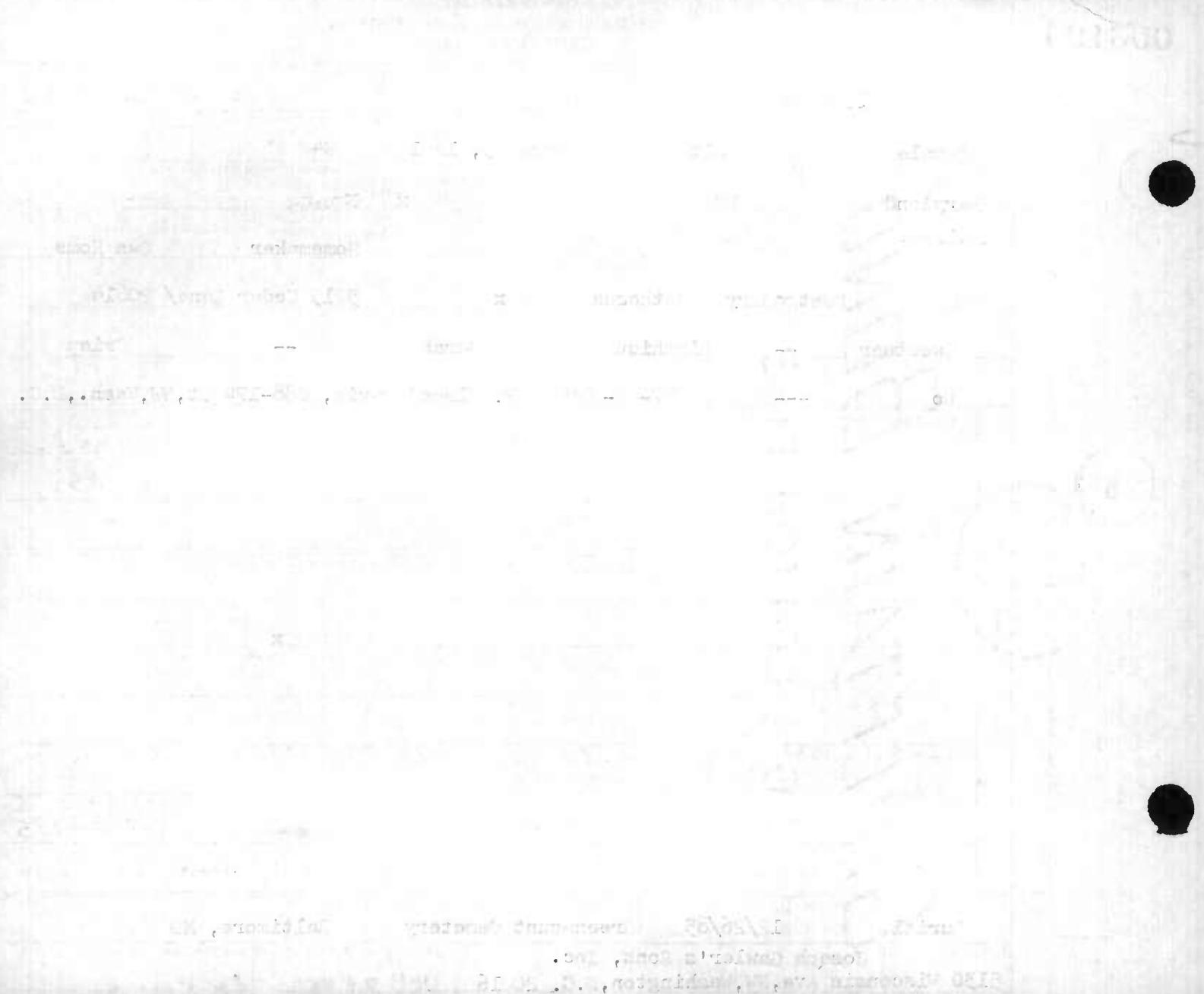
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR					
			Eleanor	L.	Woodruff	12	22	85	10:00 AM						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Female		White		March 5, 1891			94								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland		USA					Montgomery County								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
Bethesda		CARRIAGE HILL-BETHESDA								Homemaker					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
MD		Montgomery		Bethesda						5215 Cedar Lane/ 20814					
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST				
Sweetser		---		Linthicum			Sarah		---		Crisp				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		---		577-66-3398			F. Elwood Davis, 888-17th St., NW, Wash., D.C.				IMMEDIATE.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) CARDIAC ARREST															
DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROSIS															
DUE TO, OR AS A CONSEQUENCE OF (c)															
10 YRS.															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from 7/1, 1974, to 12/22, 1985, that (I) (we) last saw the deceased alive on 12/16, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Kevin G. Nealon		DEGREE M.D.		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED 12/22/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KEVIN G. NEALON		22e. ADDRESS 916 19th ST. N.W. WASH., D.C. 20006													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/26/85		23c. NAME OF CEMETERY OR CREMATORIAL Greenmount Cemetery			23d. LOCATION CITY OR TOWN Baltimore, MD		COUNTY				STATE		
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016							25a. DATE REC'D. BY REGISTRAR DEC 31 1985		25b. REGISTRAR'S SIGNATURE John F. ...						

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please attach your own carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial ceremonies, or memorial.

IMPORTANT: If Item 21 is marked on Item 18, there may be either traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_



360602

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 35369

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
<i>Charles D. Wright</i>						<i>12/18/85</i>				<i>3:20 PM</i>			
3. SEX			4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
<i>Male</i>			<i>Caucasian</i>	<i>NOV. 16, 1914</i>			<i>71 YRS</i>			MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
<i>Louisiana</i>			<i>USA</i>						<i>Montgomery Co., MD.</i>				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
<i>Silver Spring</i>			<i>8505 Spring Vale Rd. Apt 11</i>						<i>DIRECTOR</i>			<i>U.S. GOV'T.</i>	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		20910		
<i>MD</i>			<i>Montgomery</i>		<i>Silver Spring</i>				<i>8505 Spring Vale Rd. Apt 11</i>				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
<i>WALTER</i>			<i>W.</i>		<i>WRIGHT</i>	<i>CAMILLE</i>					<i>DURR</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
<i>YES</i>			<i>423-01-9480</i>			<i>MR JOHN C. WERREN</i>			<i>218 WHITMORE TERR. Silver Spring, MD</i>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laryngeal Cancer</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20701</u>	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Esophageal Obstruction</u>													
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause first. (c) <u>Metastatic Cancer</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that <u>0</u> (this hospital) attended the deceased from <u>11/2</u> , 19 <u>85</u> , to <u>11/2</u> , 19 <u>85</u> , that <u>0</u> (we) last saw the deceased on <u>11/2</u> , 19 <u>85</u> , and that in <u>0</u> (our) opinion death occurred on the date and hour and from the causes stated above. If we did not view the body after death, check <u>0</u> .													
22b. SIGNATURE			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED				
<i>John Margolis</i>			<i>MD</i>			<i>DR. JOHN MARGOLIS, M.D.</i>			<i>14333 Laurel-Bowie Rd. 307 Laurel, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN				
<i>CREMATION</i>			<i>12-18-1985</i>			<i>CHAMBERS CREMATORY</i>			<i>RIVERDALE, P.G.C. Md.</i>				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
<i>W. W. CHAMBERS CO. INC.</i>			<i>SILVER SPRING, Md.</i>			<i>OCT 23 1985 Julie Davidson-Pender</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7-84  
(VRA 15. 4)



## RELEASED BY DR. MAYLE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be relocked for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										853536				
										REG. NO.				
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR				
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	December 10, 1985							10:00AM	
James A. Wright														
3. SEX			4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Male			Caucasian		March 27, 1903			82			YRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH						
Virginia			United States		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Montgomery County			MD.			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY	
Rockville			13200 Twinbrook Parkway #304							Engineer			U.S. Government	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13c STREET ADDRESS / ZIP CODE				
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20851 13200 Twinbrook Parkway			
14 FATHER'S NAME FIRST James			MIDDLE	LAST	15 MOTHER'S MAIDEN NAME FIRST Annie			MIDDLE	LAST	Neale				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17 INFORMANT			ADDRESS					
No			578-64-6680			Doris S. Wright, same as #13								
18. CAUSE OF DEATH (Enter only one cause per line for part (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Palmonary Embolism										1 hr.				
DUE TO, OR AS A CONSEQUENCE OF (b) Deep Venous Thrombosis										12 hr.				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost										DUE TO, OR AS A CONSEQUENCE OF (c) Pyoderma Gangrenosum of legs.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) a biliary colic										2 Mo.				
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED							20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
			P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a I certify that (I) (this hospital) attended the deceased from 10/10/85 to 12/10/85, that (II) we lost saw the deceased alive on 12/14/85, and that in (my) our opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did) not view the body after death.										22c DATE SIGNED 12/10/85				
22b SIGNATURE Max Sherer, M.D.										DEGREE MD ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Max Sherer, M.D.										22e ADDRESS 800 Pershing Drive Silver Spring, Maryland 20910				
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE Dec. 13, 1985			23c NAME OF CEMETERY OR CREMATORIAL Gate of Heaven			23d LOCATION CITY OR TOWN		23e STATE Silver Spring, Maryland			
Burial														
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes 7557 Wisconsin Ave. Bethesda, MD 20814 PA									25a DATE REC'D. BY REGISTRAR DEC 16 1985		25b REGISTRAR'S SIGNATURE			

1

AMERICAN  
INDUSTRIAL  
COMMITTEE

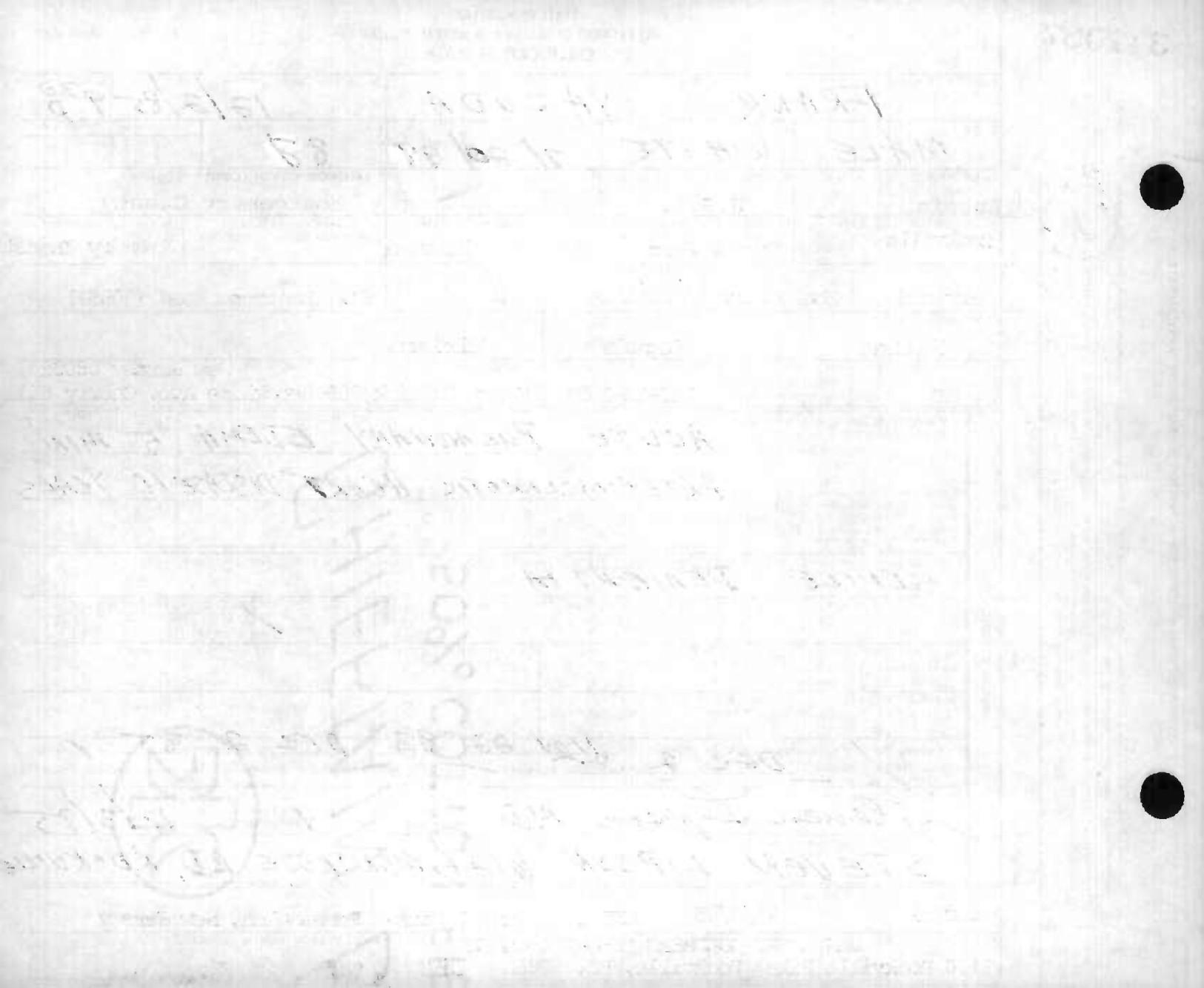
347087

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed in the funeral director's permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed and

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8535362					
1. FOR STATE REGISTRAR			1. DECEASED NAME FIRST <b>FRANK</b>			MIDDLE <b>YAGUDA</b>			LAST			2a. DATE OF DEATH MONTH DAY YEAR <b>12/12/85</b>		2b. HOUR <b>9:30 AM</b>			
3. SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH MONTH <b>7</b> DAY <b>20</b> YEAR <b>97</b>						6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>9</b> MIN. <b>30</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Russia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Rockville</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Hebrew Home of Greater Washington</b>									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY <b>Laundry Indust</b>			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Rockville</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>6121 Montrose Road (20852)</b>					
14. FATHER'S NAME FIRST <b>Nathan</b>			MIDDLE			LAST <b>Yaguda</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Miriam</b>			MIDDLE		LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>148-22-1036</b>			17. INFORMANT <b>Norma Supnick; 309 Brookline Ave.; Cherry Hill</b>						ADDRESS <b>New Jersey 08002</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						<b>ACUTE PULMONARY EDEMA</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 MIN</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			{ (b) DUE TO, OR AS A CONSEQUENCE OF <b>ARTERIOSCLEROTIC HEART DISEASE</b> (c) DUE TO, OR AS A CONSEQUENCE OF			{ (c) DUE TO, OR AS A CONSEQUENCE OF			{ (c) DUE TO, OR AS A CONSEQUENCE OF			ADDRESS <b>New Jersey 08002</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			<b>SENIILE DEMENTIA</b>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov 22, 1983</b> to <b>DEC 2, 1983</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>DEC 2, 1983</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did not <input type="checkbox"/> view the body after death.			22b. SIGNATURE <b>Steven Lipson MD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>12/3/83</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEVEN LIPSON</b>			22e. ADDRESS <b>6121 MONTROSE RD, ROCKVILLE</b>														
23a. BURIAL, CREMATION, REMOVAL <small>(SPECIFY)</small>			23b. DATE <b>12/4/85</b>			23c. NAME OF CEMETERY OR CREMATORIAL <small>ADDRESS</small> <b>Crescent Burial Park</b>			23d. LOCATION CITY OR TOWN <b>Pennsauken, New Jersey</b>								
24. FUNERAL DIRECTOR NAME <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</b>			25a. DATE REC'D. BY REGISTRAR <b>DEC 9 1985</b>			25b. REGISTRAR'S SIGNATURE <b>John T. [Signature]</b>											
1170 Rockville Pike; Rockville, Md. 20852																	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 35363

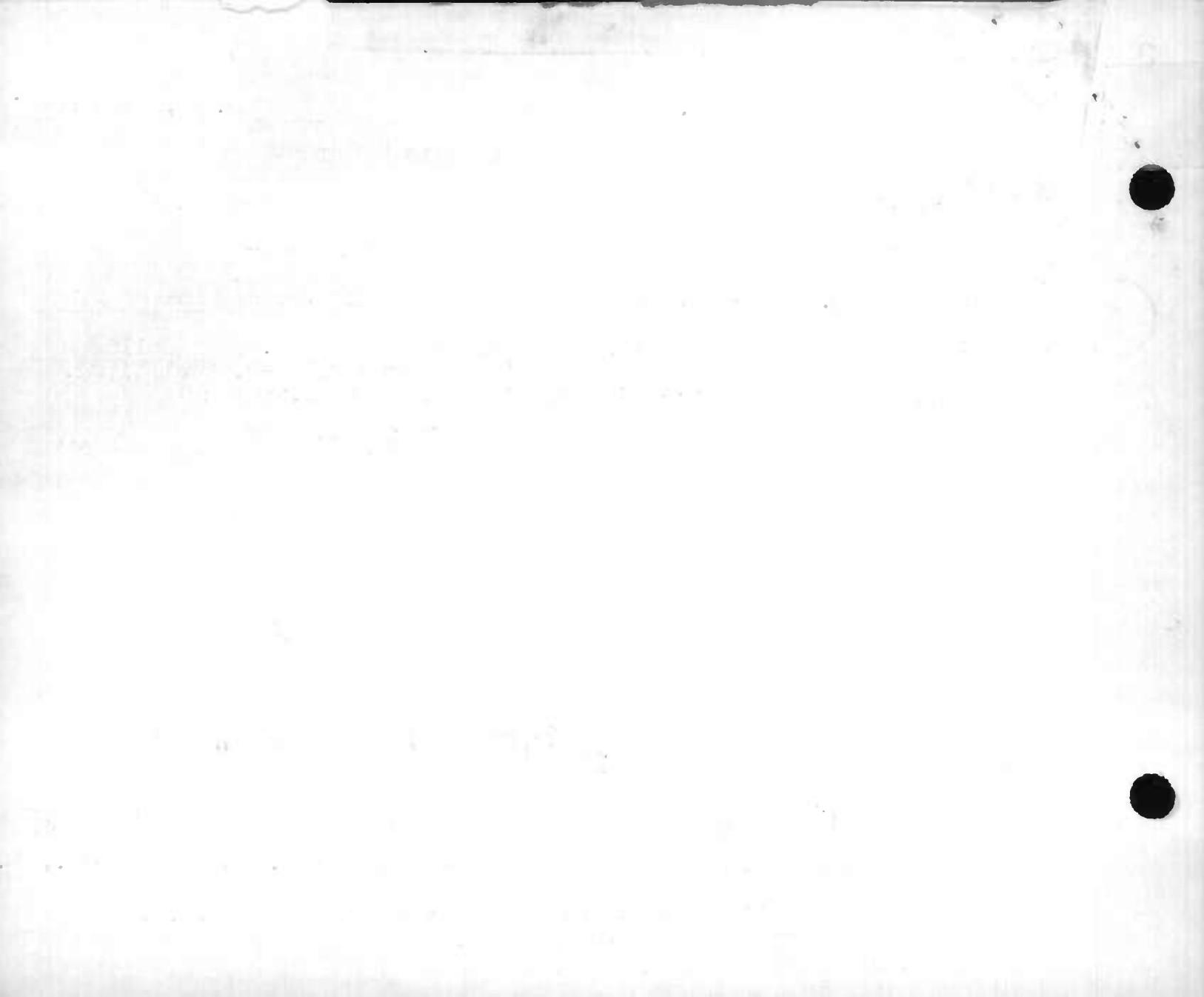
1. FOR STATE REGISTRAR			2. DATE OF DEATH				MONTH	DAY	YEAR	7b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	Dec. 11, 1985				P. 10:20 M	
Marion P. Yeatman											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		white		MONTH April DAY 11 YEAR 1918		67		MONTHS	YEARS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.	
Wash.D.C.		USA				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Akoma Park		Washington Adventist Hospital		Homemaker							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Pr. Georges		Adelphi				1515 Quinwood Street		20783	
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
		John	P.	Yeatman	Marion		N.		Collison		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
(If Yes, give war or dates)		219 64 0061		John N. Yeatman(Brother)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ovarian cancer, FIGO Stage III</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if any (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED IN HOME <input type="checkbox"/> IN OFFICE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (i) this hospital attended the deceased from saw the deceased alive on <u>12-11-85</u> and that in my (my) opinion death occurred on the date and hour and from the causes stated above. (ii) we (did) (did not) view the body after death.											
22b. SIGNATURE <u>Kai-Yiu Yeung, MD</u>		22c. DEGREE				22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <u>12-12-85</u>			
23a. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				23d. LOCATION CITY OR TOWN		23e. DATE REGD. BY REGISTRAR			
Kai-Yiu Yeung, MD		6525 Belcrest Road Rd. Suite 460 Hyattsville, Md.				Washington, D.C.		DEC 16 1985			
23b. BURIAL, CREMATION, REMOVAL (SPECIFY)		23c. DATE		23d. NAME OF CEMETERY OR CREMATORIAL		23e. LOCATION CITY OR TOWN		23f. REGISTRATION SIGNATURE			
Burial		12/14/85		Glenwood Cemetery		Washington, D.C.					
24. FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REGD. BY REGISTRAR		25b. REGISTRATION SIGNATURE			
Hines/Rinaldi Silver Spring, Md. 20904						DEC 16 1985					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT) If Item 21a is marked in Item 18, allow any injury, or other traumatic event, in medical history, which may have contributed to death.

REMARKS: \_\_\_\_\_



357045

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

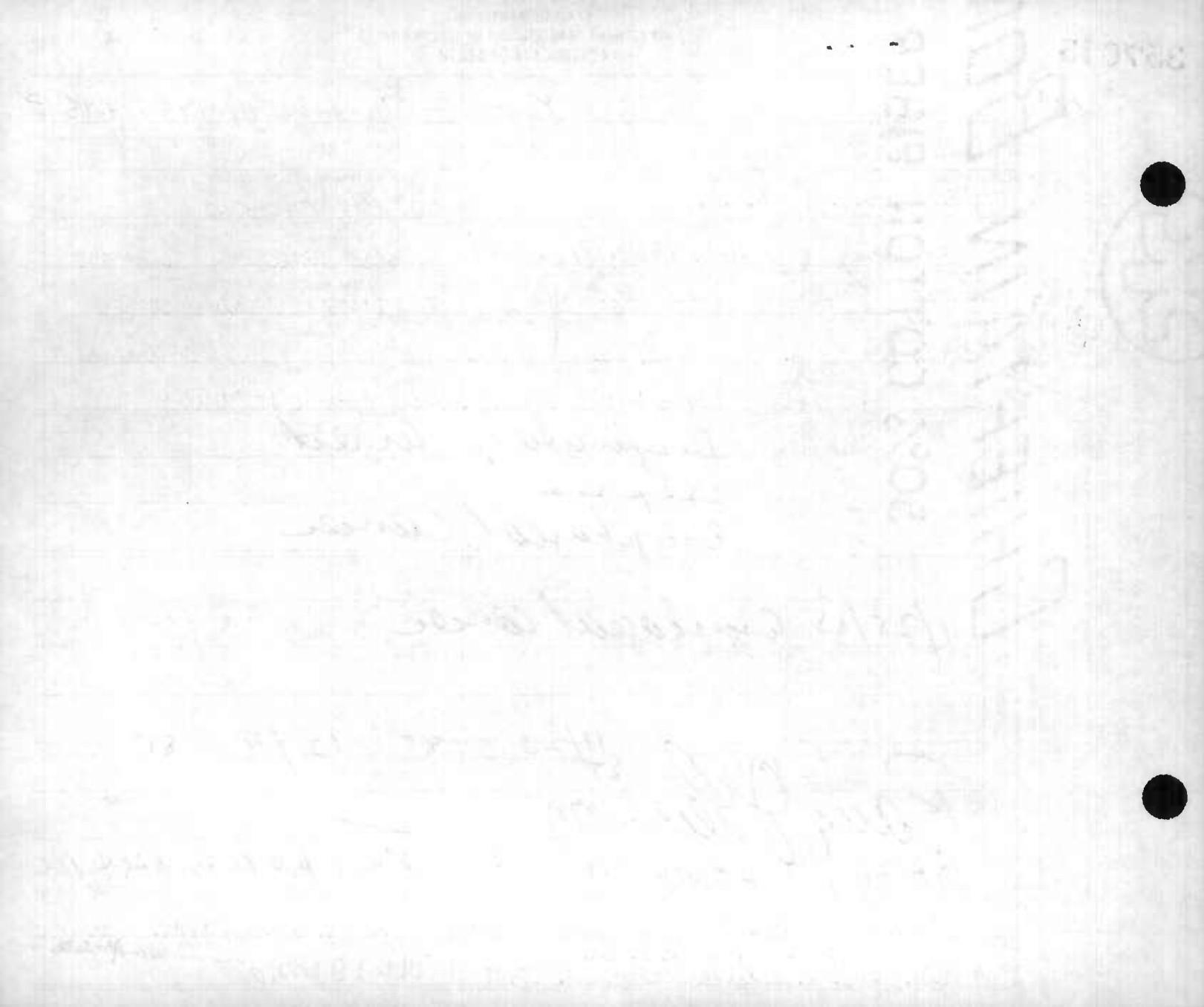
8 5 3 5 3 6 4  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
2c. SEX				3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR MONTHS DAYS				
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13. STATE Maryland				14. COUNTY Montgomery				15. CITY OR TOWN Rockville				16. STREET ADDRESS / ZIP CODE 14405 Brad Drive 20853			
17. FATHER'S NAME FIRST				18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				19. SOCIAL SECURITY NO.				20. INFORMANT			
Louis				Yes				WW II				Joyce B. Yost Same as 13 (wife)			
21. MEDICAL CERTIFICATION				22. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)				23. DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis				24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.				25. DUE TO, OR AS A CONSEQUENCE OF (c) Esophageal Cancer											
26. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
27a. DATE OF OPERATION 11/25/85				28a. CONDITION FOR WHICH OPERATION WAS PERFORMED Esophageal Cancer				29a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				29b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
29a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				29b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				29c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
30a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				30b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				30c. LOCATION STREET CITY OR TOWN COUNTY STATE							
31a. I certify that (I) (this hospital) attended the deceased from 11/20 1985 to 12/11 1985, that (I) (we) last saw the deceased alive on 19 85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not view the body after death.				31b. SIGNATURE Barry J. Levin, MD				31c. DEGREE MD				31d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
32a. PHYSICIAN'S NAME (IF OTHER THAN DECEASED) Barry J. Levin, MD				32b. ADDRESS 4801 MASS Ave N.W., WASH, D.C.				32c. DATE SIGNED DEC 19 1985							
33a. BURIAL, CREMATION, REMOVAL Burial				33b. DATE Dec. 14, 1985				33c. NAME OF CEMETERY OR CREMATORIAL Gate Of Heaven				33d. LOCATION Silver Spring, Mont. Maryland			
34. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 Univ. Blvd. W., Silver Spring, Md. 20901				35a. DATE REC'D. BY REGISTRAR DEC 19 1985				35b. REGISTRAR'S SIGNATURE Vanderbilt							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



351144

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Harry Gilmour Young, Jr.						12-06-85				10 <sup>20</sup> PM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR	
Male		Caucasian		MONTH	DAY	YEAR	82	MONTHS	DAYS	IF UNDER 24 HRS	
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Washington, D.C.		U.S.A.						Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Wheaton		Wheaton Manor Care			Self-employed			wine & Liquor Co.			
13a. STATE N/A		13b. COUNTY N/A		13c. CITY OR TOWN Washington, D.C.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4631 Yuma Street, N.W. 20016			
14. FATHER'S NAME FIRST Harry		MIDDLE Gilmour		LAST Young, Sr.		15. MOTHER'S MAIDEN NAME FIRST Laura			LAST Ferguson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-46-5895			17. INFORMANT (son) Ronald Young			ADDRESS 43208 Betty Lane Silver Spring, Md. 20904			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBROVASCULAR Accident</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>days</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (the hospital) attended the deceased from <i>Dec 5</i> , 19 <i>85</i> , to <i>Dec 6</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>6 Dec 85</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Thomas E. Dodley, M.D.</i>		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>6 Dec 85</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Thomas E. Dodley, M.D.</i>		22e. ADDRESS <i>1790 GEORGIA AVE SUITE 1, MD 20852</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/10/85		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood		COUNTY Pri. Geo.	STATE Maryland	
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr. 500 University Blvd. W., Silver Spring, Md. 20904		ADDRESS			25a. DATE REC'D. BY REGISTRAR DEC 13 1985			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be entered by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned to you, it should be retained for use as the burial-transit permit. Then please remove carbon paper. Pay attention to the following: If item 21 is marked or item 18 shows any injury, or other traumatic event, (the medical examiner will be notified).

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, (the medical examiner will be notified).

BP



008020

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 5 3 5 6 5

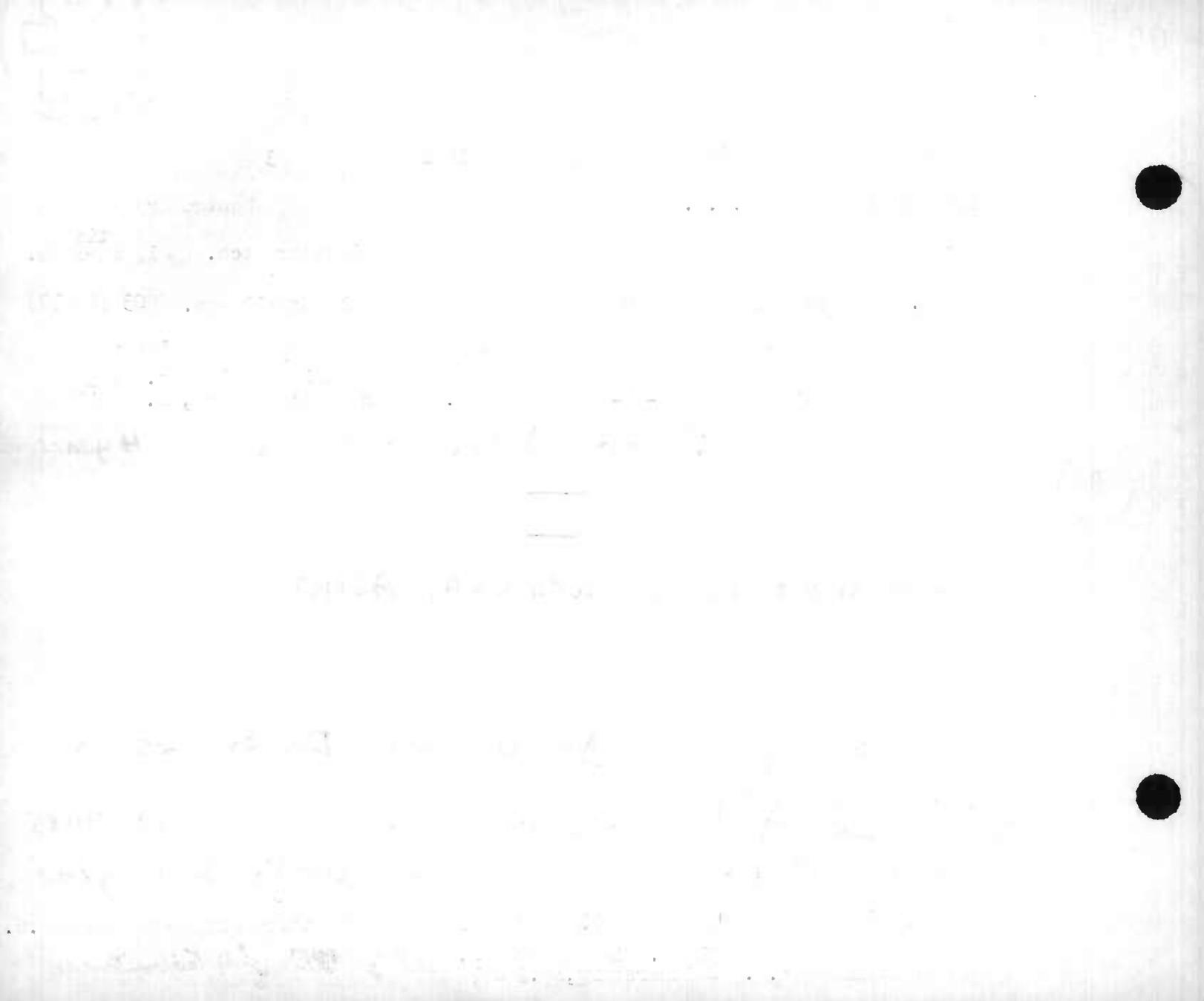
1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>RALPH</i>	MIDDLE <i>A.</i>	LAST <i>YOUNGS</i>	2a. DATE OF DEATH MONTH <i>Dec 29, 1985</i>	DAY YEAR <i>12 35 AM</i>	2b. HOUR <i>12 35 AM</i>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>May</b>		DAY <b>5</b>	YEAR <b>1902</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.	IF UNDER 1 YEAR MONTHS <b>83</b>	IF UNDER 24 HRS HOURS <b>83</b>	IF UNDER 24 HRS MIN. <b>00</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10 CITY OR TOWN OF DEATH <b>Gaithersburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wilson Health Care Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Elevator Mech.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Otis Elevator Co.</b>					
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Gaithersburg</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>401 Russell Ave. #803 (20877)</b>					
14. FATHER'S NAME FIRST <b>Abrum</b>		MIDDLE <b>Henry</b>	LAST <b>Youngs</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Grace</b>		MIDDLE <b>May</b>	LAST <b>Brown</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WWI</b>		17. INFORMANT <b>Myra C. Youngs</b>		ADDRESS <b>401 Russell Ave. #803 Gaithersburg, Md. 20877</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prostatic Adenocarcinoma</i>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) _____									
		(c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
Cerebral arteriosclerosis with CVA, ASHD											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>Nov 10, 1984</i> to <i>Dec 29, 1985</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>Dec 26, 1985</i> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I/we) <input checked="" type="checkbox"/> (did/did not) view the body after death.											
22b. SIGNATURE <i>James R. Moore Jr.</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>12-29-85</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James R. Moore Jr.</i>		22e. ADDRESS <i>207 Brooks Dr Gaithersburg Md</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/2/86</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Hollywood Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Elizabeth City (Pasquotank) N.C.</b>					
24. FUNERAL DIRECTOR <i>Roselle Sandison</i> Gartner Sandison F.H.		25a. DATE REC'D. BY REGISTRAR <b>JAN 3 1986</b>		25b. REGISTRAR'S SIGNATURE <i>Silvia Sandison Pendleton</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then place it in your carpalyn bag. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2a is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.



006109

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85 35367

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
			SAMUEL		ZATZ	DECEMBER	22, 1985			6:45 AM				
3. SEX		MALE	4. RACE	WHITE	5. DATE OF BIRTH	MAY 15, 1892								
7a. BIRTHPLACE (STATE OR FOREIGN)		RUSSIA	7b. CITIZEN OF WHAT COUNTRY?	USA	8.	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.							
10. CITY OR TOWN OF DEATH		Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY			
			Suburban Hospital			COOK					RESTAURANT			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE	MARYLAND	13b. COUNTY	MONTGOMERY	13c. CITY, TOWN	ROCKVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6121 MONTROSE ROAD	---20852---
14. FATHER'S NAME		YITZACK	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO. 579-03-2121A					17. INFORMANT DOROTHY Z. COHEN, ADDRESS 2475 VIRGINIA AVENUE, NW WASHINGTON DC		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						Pneumonia								
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause, (a), stating the underlying cause last						(b)								
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Congestive Heart Failure														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE					
22a. I certify that (I) <input type="checkbox"/> attended the deceased from December 18, 1985, to December 22, 1985, that (I) <input type="checkbox"/> last saw the deceased alive on December 21, 1985, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.														
22b. SIGNATURE Barry Hees						DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED December 22, 1985				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry Hees						22e. ADDRESS 3929 FERRARA DRIVE, INHEATON, MARYLAND 20746								
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 12/24/1985		23c. NAME OF CEMETERY OR CREMATORIUM D.C. LODGE CEMETERY		23d. LOCATION CITY OR TOWN WASHINGTON		COUNTY	STATE D.C.					
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C.						25a. DATE RECEIVED BY REGISTRAR DEC 27/1985		25b. REGISTRAR'S SIGNATURE Juliette Wilson-Parker						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be renoted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. Remit all fees to Burial Trust Fund.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

COLON

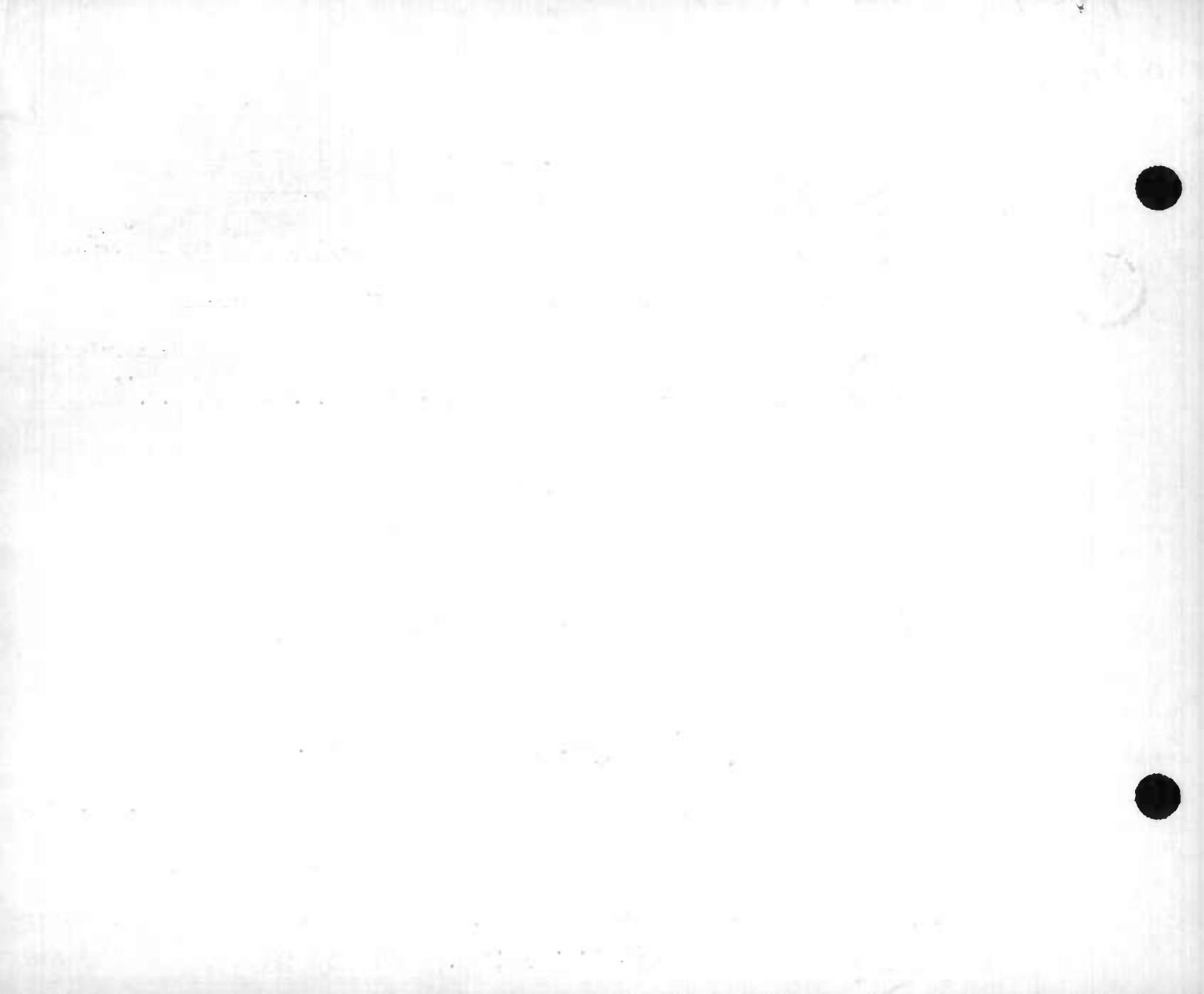
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed while retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completed, please remove carbon papers. Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 003059											
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Chester M.</i>	MIDDLE <i>Zehner</i>	LAST	2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 12-28-85 9:16 AM		
3. SEX <i>Male</i>			4. RACE <i>Caucasian</i>			5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 11 1904</i>			6. AGE (IN YEARS LAST BIRTHDAY) 81 yrs.		
7a. BIRTHPLACE COUNTRY <i>New Jersey</i>			7b. CITIZEN OF WHAT COUNTRY? USA			7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			7d. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i>		
8. CITY OR TOWN OF DEATH <i>Takoma Park</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Printer</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Naval Oceanographic</i>		
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Prince Georges</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>7208 Leona Street 20735</i>		
14. FATHER'S NAME FIRST <i>Frederick</i>			MIDDLE <i>Zehner</i>	LAST	15. MOTHER'S MAIDEN NAME FIRST <i>Sophie</i>			MIDDLE	LAST <i>Mankiewicz</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>			16b. SOCIAL SECURITY NO. <i>WW11 158-05-8866</i>			17. INFORMANT <i>Haeberle &amp; Barth F.H.</i>			ADDRESS <i>1100 Pine Ave., Union, N.J. 07083</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>SEPTICEMIA - ACIDOSIS</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>AND RENAL FAILURE</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>Diabetes - Pneumonia.</i>											
19a. DATE OF OPERATION <i>12/13/85</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>CORONARY ARTERY DISEASE</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (he/she) attended the deceased from Dec. 11, 1985, to Dec. 28, 1985, that (1) (we) last saw the deceased alive on Dec. 28, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (do) not view the body after death.											
22b. SIGNATURE <i>Samir R. Neimai, M.D.</i>			22c. DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>Dec. 29, 1985</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Samir R. Neimai, M.D.</i>			22e. ADDRESS <i>10313 Georgia Av. Silver Spring, MD, 20902</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>1-2-1986</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Hollywood Mem. Park</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Union New Jersey</i>		
24. FUNERAL DIRECTOR NAME <i>Hines/Rinaldi Funeral Home</i>			25a. DATE REC'D. BY REGISTRAR <i>DEC 31 1985</i>			25b. REGISTRAR'S SIGNATURE <i>R. Rinaldi</i>					



352053

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH35369  
REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES.  
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE TIED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF ESTI- DEATH MATED	KX MONTH DAY YEAR	2b HOUR
Alfred J. Zirwes						12-12 19 85	M	
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.			
MALE	WHITE	OCT. 13, 1906	79 yrs.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
WASHINGTON, D.C.		U.S.A.				Montgomery County, MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Wheaton		Manor Care Nursing Home				ELECTRICIAN FOREMAN RAILROAD		
13a STATE MD.		13b COUNTY MONT.		13c CITY OR TOWN TAKOMA PARK		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 8009 FLOWER AVE 20912
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		LAST		
JOSEPH			ZIRWES	ELIZABETH		WURDEMAN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
No		718-14-9059		EDNA I. ZIRWES		8009 Flower Ave. T.R.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
(b) DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held on (head only) Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>Ann M. Dixon, M.D.</u>								
TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER								
DATE SIGNED 12-12-85								
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., Md. 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Dec 16, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Ford Lincoln Cemetery		23d. LOCATION CITY OR TOWN Brookland		
Burial						COUNTY D.C. STATE Md.		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR DEC 16 1985		25b. REGISTRAR'S SIGNATURE		
Takoma Funeral Home, Takoma Park, 254 Carroll St NW DC						John Pendle		
07/84 25M BP _____ DHMH - 17 (VR A15 ME (5))								

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COLLECTOR'S



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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8535310

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Dorothy L. JOURAS						12-10	85			10:30 A.M.		
SEX	RACE				5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			
Female	White				7-26-09				76	YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?				7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH						
Greece	USA					Montgomery MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY	
Rockville	Rockville Nursing Home					Housewife					own home	
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS / ZIP CODE 11924 Tildenwood Dr., 20852				
14. FATHER'S NAME FIRST: George MIDDLE: Mantzouranis			15. MOTHER'S MAIDEN NAME Athanasia					16. ADDRESS Samartzis				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> N/A			16b. SOCIAL SECURITY NO. N/A 578-62-6208					17. INFORMANT Ethel Skenderis-daughter-(same as 13e)				
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Dysrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Kidney Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive Heart Failure</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>11-6-85</u> to <u>12-10</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>11-29-85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											22c. DATE SIGNED <u>12-10-85</u>	
22b. SIGNATURE <u>J. E. Kelly</u>			22d. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22e. ADDRESS <u>John E. KELLY</u> 9715 MEDICAL CENTER DR. <u>MD 20850</u>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-12-1985		23c. NAME OF CEMETERY OR CREMATORIAL Glenwood Cemetery			23d. LOCATION CITY OR TOWN: Washington, DC COUNTY: STATE:				
24. FUNERAL DIRECTOR NAME: Hines/Rinaldi Funeral Home			25a. DATE REC'D. BY REGISTRAR DEC 11 1985					25b. REGISTRAR'S SIGNATURE <u>John R. Rinaldi</u>				
ADDRESS: S.S. Md.												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician one completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

050-50-002